# “TELL SOMEONE WHO CARES” – PARTICIPATORY ACTION RESEARCH OF MOTIVATION AND WORKPLACE ENGAGEMENT AMONG CAREGIVERS IN AGED RESIDENTIAL CARE, NEW ZEALAND

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## Abstract

Ageing is an inevitable part of the human life cycle. Life for older adults can be active and independent, and often until late older age, but for some people older age means living in an aged residential care (ARC) facility. The New Zealand workforce in aged care health services predominantly comprises caregivers who are relatively poorly paid with limited training and are required to provide personal care to an increasingly frail population – yet they continue care for this vulnerable population. Population ageing means that while the proportion of older adults living in ARC facilities may remain the same, in future the absolute number of older adults in residential care is likely to increase Cornwall and Davey, 2004) and reliance will grow on this workforce to provide care for a vulnerable group.

The objective of this research was to understand the factors that encourage motivation and engagement of the caregivers who care for these frail people. An improved understanding of these factors will add value both economically and socially to enhance the care of older adults and improve job satisfaction and employee retention of caregivers.The methodology used for this research was Participatory Action Research (PAR), which underpinned the design of two qualitative studies. The initial exploratory study, with participants from four rural ARC facilities, identified three key themes that influenced caregiver motivation. These initial themes were developed in a subsequent study in a 42 bed facility to explore in more depth how caregiver motivation could be encouraged. The research design was based on Lewin's cycle of plan, act, observe, and reflect, which determined the four-step process. Key to the research design was the establishment of an advisory group of caregivers who developed a nine-point action plan, which was accepted by management and implemented in the facility. Their action plan included caregiver-only meetings, detailed task sheets, rotating rosters, leadership development for nurses, and a review of their performance appraisal system. The implementation of their action plan was observed and analysed, with the final results reflected back to the participants.

Data was collected via verbatim transcripts of advisory group meetings, evaluation interviews with staff, and field notes, which included observations of the process. The data was analysed using NVivo software and results informed a model describing how caregivers can be encouraged to engage more fully in their work. This model comprises three influencers (Communication, Contributing to workplace, and Caring for self), which were associated with

three key overlapping experiences (Being listened to, Having a voice, and Feeling valued) with caregiver engagement at the centre of the model. The model demonstrates that if these three influencers and the three overlapping experiences are evident in the workplace the caregivers are more likely to be engaged in their work. The model developed through this research provides potential strategies to address issues of workforce development, retention of staff, and quality of care in New Zealand ARC facilities. These will be emerging issues for our society as the population ages and requires an increased health services and the health workforce becomes constrained.

## Conference Presentations Arising from this Thesis

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## List of Abbreviations

ADL – Activities of Daily Living

ARC – Aged Residential Care

DHB – District Health Board

HWNZ – Health Workforce New Zealand

InterRAI – International Resident Assessment Instrument

JP – Jenny Prentice (researcher)

MOH – Ministry of Health

NASC – Needs Assessment Service Coordination

NZNO – New Zealand Nurses Organisation

PAR – Participatory Action Research

RN – Registered Nurse

SSHW – Safe Staffing and Health Workplace Unit

UK – United Kingdom

US – United States

WL – Associate Professor William Levack (supervisor)

# Chapter One: Background

## 1.1 Introduction

Ageing is an inevitable part of the human life cycle. For many, life in older age is fulfilling, active, and independent, often until late older age. At this time, perhaps in the eighth and ninth decade of life in New Zealand, some people may experience a short decline in health status before death. However, for a substantial proportion of people, especially those over 85 years, older age brings health and social challenges that result in time spent living in an aged residential care facility ( Broad et al., 2015). Even if the proportion of older adults who use aged residential care (ARC) remains the same over coming decades, the absolute number of older adults in these facilities is expected to increase due to population ageing (Cornwall & Davey., 2004). In ARC facilities, those staff delivering the majority of the care are caregivers who typically have limited training, work as part of an unregulated healthcare profession, and are paid poorly for the delivery of these services (Kiata, Kerse, & Dixon., 2005). Furthermore, the reliance on this workforce to provide personal care for these vulnerable people is expected to continue to grow over time (Badkar, Callister, & Didham., 2009). This thesis aims to explore how best to understand what factors encourage these caregivers to be engaged and motivated in their work with frail older adults. An improved understanding of caregiver engagement has the potential to add value to the ARC sector economically and socially, in terms of improved care for older adults, improved job satisfaction for care providers, and lower staff turnover.

My interest in this research topic has arisen from my experience over many years as a social worker in the hospital-based aged care services and then as a manager of a large, urban ARC facility providing care to 110 residents. I have watched the scope of this workforce role stretch to providing more complex care for increasingly frail residents. For some, caregiving seems to be a vocation. These people can be observed demonstrating high levels of dedication to their work, and a genuine commitment to care and respect for the older adults they work with. For others, however, caregiving seems to be merely a job; a series of tasks to be completed for pay. Despite low pay and high expectations of the skill levels required, many continue to work in the sector. Gaining a greater understanding of this workforce and their motivation to do this work would add value to how we deliver care to our elderly people in

residential care. This first chapter provides an overview of the context of ARC in New Zealand, before presenting the research question that this thesis addresses.

## 1.2 The context of ARC in New Zealand

### 1.2.1 Strategic policy

At a strategic level, provision of health services for older people (usually those over 65 years of age) in New Zealand is guided by the Health of Older People strategy, developed by the Ministry of Health (MOH) in 2002 and reviewed in 2016 (MOH, 2016). This strategy describes a vision for how the health of older people should be supported in this country. The strategy has eight objectives, which indicate areas that would enable the achievement of the overall vision, summarised in the following:

> "This Strategy applies a life course approach to achieving the aim of healthy ageing. This recognises that we age in different ways and have different needs at different times, and that our health is affected by our environment. The approach involves enhancing growth and development, preventing disease and ensuring the highest capacity possible throughout life." (MOH, 2016, p. 7)

Following a review in 2016, the refreshed 2016–2026 strategy guides the delivery of healthcare to older people in New Zealand. The refreshed document continued the current strategic focus on enabling older people to live well and independently for as long as possible but also introduces a new focus on providing quality end of life care.

The current overall policy direction for the health of older people is often described by those who work in the health of older people sector as "ageing in place", and this concept of service delivery has guided the provision of services to older people for many years. The underlying premise is that older people will remain in their own homes as long as possible with personal care and other support services being delivered in the home as a first choice. This approach has developed two types of caregiving workforce for older people: 1. community caregivers who go into peoples' homes to deliver services, and 2. caregivers in ARC who work in a residential facility dedicated to providing care to older people. It is the ARC caregiver workforce that is the focus of this thesis.

If an older person is unable to be cared for at home, they can be admitted into a facility in the residential care sector to ensure their needs are met. Section 1.1.3 provides a detailed description of the process of assessment and eligibility for admission to residential care.

While the 2016–2026 Health of Older People strategy does not specifically address aspects of the delivery of ARC services, it has reference to the integration of public hospital and residential care services so that inappropriate long-term care is avoided and the policy direction is maintained (MOH, 2016).

The workforce to support this policy is mentioned in the strategy with a comment about the need for action to ensure the provision of training in age-appropriate care in general hospital and psychiatric units. It does not provide any guidance on how the increasing number of older people requiring residential care, as opposed to public hospital care, will be provided for in terms of health service quality and standards of delivery. However, it does comment on the difficulties of maintaining sufficient numbers of nursing and medical staff and the need to support and develop caregivers, who are referred to in the document by the more generic term of kaiāwhina. A detailed description of this term can be found in section 1.3.4.

### 1.2.2 Funding

The delivery of ARC in New Zealand is through a mixture of private providers who run their facilities as businesses for profit and other providers who have a model of not-for-profit ownership. The not-for-profit providers are a mix of private individuals and religious/welfare organisations. While the public health system funds long-term care for older people, it no longer directly provides services in the form of long-term care facilities. Public funding for providers of ARC comes from general taxation and is distributed by Vote Health. The funding model is complex with a number of providers, all of whom have different business imperatives, in a competitive market and in the context of a sensitive political environment.

Funding is distributed by a contractual arrangement. ARC facilities have annually negotiated contracts for service provision, a process that was established in 2003, which are negotiated with local district health boards (DHBs). Individual ARC facilities are responsible for providing care on a number of levels; for example, rest home, hospital, and secure dementia care. The contracts are relatively generic and based on a common template across New Zealand.

Individual entitlements to funding for people assessed as requiring residential care are subject to means and asset tests. These are administered by the Ministry of Social Development and have transparent limits which take into account marital status and whether one partner is already in care. There is a maximum amount required to be paid by people assessed as

needing residential care, which is capped but varies by geographical region. Private co-payments can be required if individuals do not meet means and asset test thresholds.

### 1.2.3 Regulation and licensing

The funding contracts are one of the ways in which the ARC sector is regulated and these contracts have clear service specifications against which each ARC facility is measured to ensure the quality of care delivered. In addition to a contract for services delivered, ARC facilities require an operating licence to continue providing services, and these are guided by legislation under the Health and Disability Service (Safety) Act 2001 to ensure compliance with the Health and Disability Sector Standards 2008 (Standards New Zealand, 2008). Providers in this sector must comply with this legislation and adhere to these standards. This compliance is managed through formal and thorough auditing processes. These compliance processes have changed over the years in response to concerns about the quality of care delivered. The process now includes a planned certification audit and surveillance audits. A certification audit is prearranged with a facility and, after passing the audit, a facility is certified for providing services for a period of one to four years. A surveillance or "spot audit" is usually conducted three months either side of the half-way point of this certification. This surveillance audit occurs without notice and is intended to ensure consistency of standards of care. The process of conducting an audit has also changed, most notably with the introduction of "tracer methodology". In this process a named resident's care is tracked through all the relevant documentation from admission to the audit date, to ensure all care described as being delivered has been received. The audits must be done by designated audit agencies approved by MOH. The standards are different for each of rest home, hospital, and secure dementia level care. To ensure an open and transparent process these audit reports are publicly available on the MOH website. Potential residents and families are encouraged to read these as part of considering admission to an ARC facility. There have been grave concerns about the quality of care delivered in ARC facilities and often these unpleasant situations have been the focus of media attention (Stuff National News, 2016). The audit process is an important part of ensuring that older frail residents are not subjected to inappropriate or, on occasions, harmful experiences.

For an individual to be eligible for residential care they must be assessed by a separate group of organisations, which may be integrated with or separate from (and contracted to) local

DHBs. These organisations are called Needs Assessment Service Coordination (NASC) agencies and they employ experienced registered nurses (RN) as needs assessors. A number of tools have been used over the years to assess the need for residential care, the most recent of which is the "International Resident Assessment Instrument" provided by a health organisation – Central Region Technical Advisory Services Ltd (TAS). This is an organisation providing strategic, advisory and programme management service to the health sector. This tool has been developed with international collaboration and is commonly known as the interRAI. It provides a common tool for assessing residents who require long-term care and became compulsory for use in ARC facilities in 2015. The purpose of the tool is to provide substantial data to describe the level of acuity of people in residential care across New Zealand. The use of the interRAI will, in time, provide a common database to identify trends and issues in the acuity of older people in ARC, as it is used for all assessments of people admitted to residential care. Reports on this data provided by TAS will inform potential demands on workforce and ARC facilities and improve on the current limited data on needs of older adults in or considering admission to ARC. To be eligible for funding an individual must have their needs assessed as high or very high and indefinite, that is, not reversible. Eligibility is also age-based and in general an individual must be aged over 65 years; or between 50 and 64 years and unmarried with no dependent children at home.

### 1.2.4 Characteristics of residents in ARC

Four cross-sectional studies of ARC facilities have been conducted in Auckland in 1988, 1993, 1998, and 2008. In 1988 23% of people in rest homes were rated as independent (Broad et al., 2011); by 2008, the number of residents who were considered to be independent and able to provide most of their own care had fallen to 7%. Independence in this study was determined by various levels of functionality of people in residential care, e.g. for example, people who were able to shower without help. The percentage of residents who are regarded as not being independent, that is, unable to shower without help, rose from 74% in 1988 to 90% in 2008 and those who were unable to move from bed without help rose from 14% in 1988 to 21% in 2008. This shows that over time there has been an increase in the care required to support those admitted to ARC and consequently an increase in the need for caregivers to care for a more frail population. While this study explored some of the changes in physical dependence there is currently limited data on the prevalence of dementia present in residents in ARC. Anecdotally, facilities report more residents at rest home level care (excluding those people requiring secure dementia care) who have some degree of cognitive

impairment. The presence of some cognitive impairment does have impact on the residents' ability to provide their own care, for example, being unable to put on clothes in the right order, which in turn increases the level of dependence. Caring for these people requires a higher skill level as they are often unable to follow simple instructions and can be very frustrating to work with. The increasing number of people with dementia suggests that a higher skill level will be required by more caregivers so they can provide for the complex needs of these residents.

It can be implied that the "ageing in place" strategy supported by comprehensive assessment tools and well monitored funding models has resulted in decreased numbers of people in ARC. This is supported by the data, that indicate 7.4% of over 65-year-olds were in residential care in Auckland in 1988, reducing to 5.3% in 2008 (Boyd et al., 2009). This would appear to be a desirable outcome that supports the strategy to keep people in their own homes as long as possible. However, when considered alongside the increasing dependence of residents and increasing mental frailty a significant change is occurring in older people accessing residential care. The requirement for facilities to care for a much frailer group of residents is inevitable. As the total number of older people increases with an ageing population who are frailer when they enter ARC, it is worth considering how the workforce will need to change and grow to meet this change in demand.

## 1.3 The ARC caregiver workforce

### 1.3.1 Demographic characteristics

The ARC caregiver workforce, as with many of the health care services, is predominantly female (Badkar et al., 2009) and older in age. A detailed survey of staff in New Zealand ARC facilities ($N$ = 845) Kiata et al., (2005), found that 92% of caregivers were female and that 52% of caregivers were between 25 and 45 years, with 36% between 45 and 60 years. A more recent survey conducted by the Work Research Unit, Auckland University of Technology, of 2034 aged care workers with 266 respondents (a 13% response rate), confirmed a similar workforce demographic profile; 95.4% of the residential caregiver workforce was female and 73.6% were over 40 years of age Ravenswood, Douglas, and Teo (2015). The ARC workforce has also been described as ethnically diverse with all of the facilities in the study ($N$ = 845) reporting that many of their staff members speak English as a second language (Kiata et al., 2005). Staff turnover is also described as high with 43% of people leaving ARC work within two years Kiata et al.,( 2005). This study, although somewhat dated, is likely be to relatively

representative of the ARC workforce as 55% (845/919) of all ARC facilities in New Zealand participated. Potential strategies for increasing the migrant workforce were explored in a working paper from the Institute of Policy Studies. In the paper strategies for the development of a migrant workforce in ARC, which could meet the rising demand for services, have been explored (Badkar et al., 2009). While increasing the number of migrant workers provides a viable strategy for meeting the gap between demand and supply for caregivers, this does come with some challenges, for example, difficulties of retention, tension with existing migrant groups, and complex relationships with the local workforce.

Another demographic characteristic of the ARC caregivers is that anecdotally they are not a well-trained workforce. However, Health Workforce New Zealand (HWNZ) has attempted to improve the training opportunities for this workforce, described in more detail in Section 1.3.5. One strategy to address this is to consider career development pathways for caregivers. In recognition of this, a specific action in the HWNZ Workforce Action Plan (HWNZ, 2018) is career development. Work on career development for caregivers in the Workforce Action Plan led to the development of a vocational pathway programme in 2016.

The relevance of education of staff and quality of care can be seen in a pre- and post-evaluation intervention study by Smith, Kerse, and Parsons., (2005). This study assessed the impact of a single, face-to-face education session for 15 caregivers and 41 residents on Activities of Daily Living (ADL) in a single ARC facility in Auckland. Impact was measured using the Quality Assessment Project scoring system, to score the delivery of care on four dimensions (Adequate/Inadequate and Appropriate/Inappropriate). The programme used case studies, visual tools, discussion, and story-telling and the study found there was a positive impact on the reported delivery of care. Although a small sample of residents participated ($N$ = 39) the study showed a significant increase in appropriate care ($p$ = 0.001) and a decrease in inappropriate care ($p$ = 0.0005). It is important to note that these types of initiatives to encourage increasing the level of education of the caregiver workforce have potential to improve care quality in ARC.

### 1.3.2 Remuneration

This ARC caregiver workforce is usually paid at or just over the minimum wage. Both private and not-for-profit providers are constrained by the government funding model, which caps the cost of care. Some facilities charge additional fees for premium rooms or have business models that include a property development portfolio that can enable higher returns and

therefore higher wages. However, these models rarely result in benefits that are passed on to the workforce. Internationally, low pay rates for ARC workers have been found to have a negative effect on retention in the workforce (Travis, 2007). Dissatisfaction with pay rates is also a feature of the New Zealand caregiver workforce with a survey by Ravenswood et al. (2015) indicating that 89.3% of the 574 caregivers responding were not satisfied with their wages.

In 2017 the New Zealand government, in response to a pay equity claim, implemented a pay increase for all ARC caregivers (MOH 2018). The full impact of this on caregiver retention is not yet clear, although initial anecdotal comments would suggest that caregivers from other parts of the health sector, for example, mental health support workers, are moving to ARC for the higher level of pay. Anecdotal reports also suggest that the pay increase will have a flow-on effect on the wider workforce, for example, nursing and cleaning staff, and the pressure for funding for increases to these staff may well have a negative impact on the viability of some smaller facilities (Stuff National News, 2017). This increase to ARC caregiver wages could have longer term impacts on the availability of choice in an ARC facility for older people as it may be that only the larger providers will remain financially viable and in the market. This does have significant implications for older people and families living in rural areas or areas with limited transport options. It could mean they are unable to maintain regular contact with their family members or incur significant financial cost to be able to continue this contact.

The importance of retaining a viable workforce has been the subject of research by MOH (Cornwall & Davey., 2004), particularly the potential influence of low rates of pay on the retention of this workforce. This is also evident in the Ravenswood et al. (2015) study, which indicated that 45% of their survey respondents were considering leaving their job, although most of these respondents indicated this was for reasons not directly related to employment conditions (e.g., retirement or moving away). Retaining these workers will become an important issue for the future of care delivery in ARC with growth in the absolute numbers of older people requiring residential care. The findings of the surveys, noted above, highlight the need to continue to find ways to address issues of recruitment and retention in the caregiver workforce. This is a matter of urgency as by 2036 an estimated 48,200 caregivers will be needed to provide residential care in New Zealand and the local labour supply may not be able to meet this demand (Badkar et al., 2009). This thesis proposes to explore strategies for gaining improved understanding of the motivation of the caregiver workforce, which may suggest alternative ways to address these issues.

### 1.3.3 Staffing levels

Another key issue in the work environment of ARC caregivers is that of staffing levels. The workload, as currently configured, is mostly task centred and focused on delivering both physical and emotional personal care. At the most dependent level of care, hospital level care, two people are often required to assist residents with basic activities such as eating, dressing, and bathing. The number of staff available to do this work is critical to the ability of those caring for residents to provide safe, timely, and high quality care. The New Zealand ARC sector has no mandatory staffing levels, although those facilities providing hospital level care are required to have a RN on all duties. This means that each facility maintains a self-determined level of staffing relevant to the level of care provided. The three broad levels of care in New Zealand ARC largely reflect historical patterns of licensing and funding of care but in broad terms constitute: (1) rest home, (2) hospital, and (3) dementia levels of care. Discussion on issues relevant to enabling safe staffing levels is outlined in work done by the Safe Staffing and Health Workplace Unit – a collaborative work programme between the New Zealand Nurses Organisation (NZNO) and DHBs, who set up a specific unit to explore these issues as part of a collaborative effort between the two organisations (New Zealand Nurses Organisation, 2014). This unit's programme of work looked at staffing levels for the registered health workforce, but it seems no progress has been made on determining what constitutes safe staffing levels for the unregulated workforce.

The relationship between quality of care and staffing is reported in a longitudinal study conducted in 44 ARC facilities in the Auckland region, including both hospital and rest home levels of care (Whitehead, Parsons, Dixon, & Robinson., 2015). The impact of staffing levels (of both RNs and caregivers) on five quality measures (falls, weight loss, urinary tract infections, use of over nine medications, and use of indwelling catheters) was explored using longitudinal descriptive survey methodology. Although this study must be interpreted with caution because of its small sample size, and therefore its potential to detect statistically significant differences, the findings suggested that there was no support for a relationship between quality of care and the number of caregivers. However, some indication existed of a link between the quality of care and numbers of registered nursing staff. While this is a useful finding, the higher cost and, at times, limited availability of registered nursing staff will mean that caregivers will continue to influence the quality of care in ARC. Therefore, it is of some interest to explore the engagement and motivation of this workforce to lead to better understanding about the relationship between caregivers and quality of care in ARC.

### 1.3.4 Workforce regulation

Regulation of the health workforce in New Zealand is through the Health Practitioners Competence Assurance Act 2003. This Act provides a legal framework to ensure protection of the public from substandard clinical practice. In the workplace caregivers work alongside other healthcare professionals such as RNs, doctors, and allied health professionals who are subject to these regulatory standards. However, although caregivers are one of the groups excluded from coverage by this legislation with no direct regulatory framework for their role, as a workforce they are still subject to the provisions of the Health and Disability Commissioner Act 1994, which ensures that all people in New Zealand receiving any heath service have access to a Code of Rights that is enforceable. Any breach of the rights can be reported to the Health and Disability Commissioner and may be investigated and, if needed, prosecution can follow. Nevertheless, this lack of professional regulation means that there is no mechanism by which the public are protected from poor standards of service delivery from this specific workforce, as noted in section 1.2.3.

### 1.3.5 Workforce development

HWNZ has a legislative mandate and leadership role in developing the New Zealand health workforce (Naccarella, Greenstock, & Wraight, 2013). To this end, HWNZ has identified that caregivers in ARC are part of a wider support workforce called "kaiāwhina". This term is defined on the web site, developed jointly with the industry training organisation Careerforce, as "the over-arching term to describe non-regulated roles in the health and disability sector" (HWNZ, 2018, p. 1). The term does not replace the specific role titles, for example, caregiver, health-care assistant, orderly, mental health support worker. HWNZ developed a five-year action plan as part of a 20-year vision for the development of this workforce. The plan addresses seven areas or "domains": 1. access, 2. career development, 3. workforce recognition, 4. consumer focus, 5. quality and safety, 6. workforce intelligence, and 7. sustainability. As of April 2016, Careerforce has begun work in all seven domains. The ARC caregivers are a subset of this workforce as they have some shared characteristics with the wider group with regard to their lack of regulation, lack of training, and low pay rates. It is imperative that initiatives that lead to increased workplace engagement, professional development and work satisfaction are identified and widely implemented to provide increased stability for this low skilled and marginalised workforce. This will be essential for ARC to remain sustainable and meet the needs of New Zealand's frail older adults.

## 1.4 Research question

This chapter has given an overview ARC, which is a highly important yet complex part of the New Zealand health sector. Strategic policy, funding mechanisms and regulations all influence how care is delivered by ARC facilities. The elderly people they care for are increasing in absolute numbers as illustrated by New Zealand census data (Statistics New Zealand, 2013*)* and therefore the numbers of people with a degree of physical and mental frailty will also increase. The challenge is how to meet the rising demand for care and provide this care to a high quality standard, especially with the current workforce. The majority of the ARC workforce is caregivers who are unregulated, sometimes not well trained and not well paid. Therefore, this thesis aims to:

1. Develop a better understanding of the factors that encourage ARC caregivers to be motivated and engaged in their work, and
2. Develop and test methods for better caregiver workplace engagement in an ARC facility.

If the factors that help ARC caregivers to be motivated and engaged with their work can be identified and addressed, this workforce has the potential to deliver higher standards of care to one of the most vulnerable groups in our society.

## 1.5 Structure of this thesis

This first chapter provides an overview of the ARC sector, the specific nature of the ARC caregiver workforce and introduces the aims of this thesis. Chapter Two is a literature review considering four broad areas relevant to caregivers in ARC and to this thesis – motivation, job satisfaction, workforce engagement, and current research into the ARC workforce in New Zealand.

Chapter Three details an initial exploratory study that explored the factors that may encourage engagement of the caregiver workforce. The initial plan for this thesis was to test strategies to improve the work experiences of ARC caregivers. However, this exploratory study indicated that a more detailed research approach was required. Consequently, a Participatory Action (PAR) research approach was chosen used to ensure that the caregiver motivation and workplace engagement was more deeply understood.

Chapters Four and Five describe the Participatory Action Research (PAR) methodology chosen following the exploratory study in Chapter Three. The results from this second study, expanded on and tested issues arising from this initial exploratory study. The final discussion

chapter considers conclusions from both the exploratory study and the PAR study and discusses implications of this work for the future.

# Chapter Two: Key Concepts and Literature Review

## 2.1 Introduction

This thesis aims to develop a better understanding of factors that encourage ARC caregivers to be motivated and engaged in their work of providing care for frail older people. The goal of the literature review in this chapter was to identify and evaluate relevant research in relation to motivation and engagement. Although this was not a systematic review, because of the wide range of potentially relevant search terms for these issues, the review used a systematic approach in an attempt to reduce bias in inclusion of relevant background literature.

The ARC workforce comprises mainly caregivers and other service workers, for example, laundry, kitchen, and cleaning staff, some recreation officers and a lesser number of registered nurses (RNs) who provide clinical and professional leadership. As described in Chapter One, caregivers are unregulated workers, meaning that they are not subject to oversight from a professional registration body: nor do they have a profession-specific complaints and disciplinary process under the Health Practitioners Competence Assurance Act. They are predominantly untrained, although the Industry Training Organisation (Careerforce New Zealand) does offer some training and qualification options linked to the New Zealand Qualifications Authority framework.

As noted in Chapter One, this workforce is mostly female, older, and is typically paid just over the minimum wage. These workers provide full personal care for older adults living in ARC facilities. This comprehensive type of care includes physical cares, for example, assistance with toileting and showering, as well as emotional and other social support. In the experience of JP, residents become more dependent caregivers and can, in their development of a relationship with the resident, caregivers become the most important person in the resident's life, and may be relied on to provide the full range caring practices. Although the amount of physical assistance with personal care varies for each resident, all residents require some form of assistance. This assistance can range from simple supervision of basic activities of daily living, for example, dressing and showering, to full assistance from two people with all basic activities including feeding, mobility, and continence care.

ARC facilities in New Zealand are subject to rigorous and transparent auditing processes as well as contractual obligations. External audits and contracts provide close monitoring of the standard of care delivered in these facilities and is underpinned by a legislative framework.

Other workplace factors associated with the organisation culture and the employees who work in facilities such as job satisfaction, teamwork, and employee engagement may also affect the standard of care provided. This literature search aims to provide a broad understanding of the context for this thesis.

## 2.2 Search strategy

The literature search used to identify relevant research for this chapter utilised electronic databases searched using specific topic-related concepts. The electronic databases used were: Medical Literature Analysis and Retrieval System Online (Medline®); Psych-INFO®; The Cumulative Index to Nursing and Allied Health Literature (CINAHL); and Google Scholar, New Zealand. Specific grey literature, comprising sources of information such as theses and conference abstracts, was searched using the database in New Zealand research website provided and run by the National Library of New Zealand. All searches were limited to material published in English since 2000.

The search terms used to identify relevant literature included:

1. Quality of health care
2. Long-term care
3. Residential care workforce New Zealand
4. New Zealand aged residential care
5. Aged care workers New Zealand

These concepts were also combined with the more general conceptual terms of motivation, employee engagement, workforce issues and job satisfaction to identify relevant literature. The search was expanded to consider any other research, besides that on motivation, into the ARC caregiver workforce in New Zealand, for example, their role in the prevention of falls. Articles were then identified for their relevance to the research question and the selected articles were critically evaluated for potential to give more depth to the understanding of how ARC caregivers experience their work.

The next section in this chapter gives an overview of the concept of workforce motivation; followed by two sections that describe the identified literature relevant to an understanding of specific factors, that is, job satisfaction and employee engagement in the aged care sector. The final section discusses the literature relevant to an understanding of issues for the New Zealand ARC caregiver workforce.

## 2.3 Overview of the two-factor theory of workforce motivation

Motivation is a primarily psychological term that describes why human beings engage in particular tasks or behaviours and is at the centre of the research question posed in this thesis. This literature review did not explore the topic of motivation as it is an extensive area of research in its own right. Nonetheless, this section provides a general overview of the two-factor theory of motivation that is particularly pertinent to this thesis.

Herzberg, Mausner, and Snyderman., (1959) described the two-factor theory of intrinsic and extrinsic motivation to explain why human beings engage in tasks. Intrinsic motivators are the factors that drive a person internally to do a task, for example, their satisfaction in their work or a desire to achieve a personal goal. Extrinsic motivators are the factors external to the person that drive a person to achieve tasks, for example, pay rates, or legislative requirements. Herzberg et al argued that although both factors are important, intrinsic motivators are more sustainable over time than extrinsic motivators. One of the most commonly used external motivators is that of monetary reward, specifically remuneration packages. Extrinsic motivators, they argued, lose efficacy over time, while intrinsic motivators (such as job satisfaction) will consistently provide motivation for the longer term.

Since Herzberg and colleagues first described this theory of motivation, further research into the relevance of the theory supported it as a worthwhile construct. A 2005 UK study of 32 organisations across seven organisational sectors concluded that the notion that workers are motived by both intrinsic and extrinsic factors was still valid (Bassett-Jones & Lloyd., 2005). This study revisited the literature that explored the concept of motivational theory and used a survey to explore the more specific two-factor motivational theory in the context of "What motivates employees to contribute ideas?" Bassett-Jones & Lloyd, (2005)., p. 929. They used a stratified sample approach that included the sectors of government, police, manufacturing, financial, retail, utilities, and services and received 3200 responses – a 64% response rate. In each of these sectors, motivators associated with intrinsic motivation, for example, a desire to overcome frustration in the workplace outweighed the extrinsic factors, such as pay. The importance of managerial recognition, which had been a key driver of motivation in Herzberg and colleagues' research, was no longer as prominent, and the researchers posited this had been a result of fewer promotion opportunities in organisations with shallower hierarchies. The findings of this study may be limited by response bias related to limitations in the sampling process, but it still supported the two-factor motivational theory as a valid construct.

It seems likely that this model could meaningfully be applied to the ARC organisational context.

Two identified studies illustrate aspects of two-factor motivational concepts in a healthcare setting that are relevant to understanding the context of the thesis question. A study by Travis (2007) considered the two-factor theory of motivation in a comprehensive health service environment. The second study by Drebing, McCarty, and Lombardo., (2002) considered the two-factor theory of intrinsic and extrinsic motivators for caregivers in specialist dementia programmes.

The research design of the study by Travis (2007) used data from a large-scale US study (1995–1998), which included 386 workers in 12 health service organisations, to explore the two-factor motivation theory in relation to human service workers and whether they could be solely motivated by the intrinsic aspects of their work. Detailed demographic data and survey responses reflecting overall job satisfaction were used in a pathway model to explore the links between the variables. They specifically explored the link between the variables that would support the assumption that the need to be doing good work in an altruistic sense goes a long way to motivating human service workers in their work. The model identified five variables that were associated with survey responses consistent with overall job satisfaction: (1) empowering management practices, (2) personal responsibility, (3) service quality perceptions, (4) extrinsic job satisfaction (satisfaction with rewards) and (5) intrinsic job satisfaction (satisfaction with work and relationships). In the analysis the author concluded that the concept of having a sense of personal responsibility to do well and providing a good quality of service were not enough to completely influence intrinsic job satisfaction. Extrinsic satisfaction and empowering management practices were also important in influencing the overall job satisfaction of the workers. The author also demonstrated that while intrinsic motivation played an important part in workplace motivation for these workers they were also motivated by extrinsic factors. Limitations of the study include a lack of detail on how the organisations were selected, raising the possibility of selection bias. Additionally, the study was US-based and may not be generalisable to the ARC workforce in New Zealand. The study also used data reports that may now be out of date with respect to work-place practices. However, this research supports the view that just “doing good” may not be enough to generate motivation for work. Workers in human services need extrinsic factors, such as empowering management practices and rewards, as well as the intrinsic factor of altruism to be motivated in their work.

The second study, by Drebing et al., (2002), aimed to identify factors that could predict whether professional caregivers would stay in a caregiving job and continue in this career. They used secondary analysis of data from the Boston University Alzheimer's Disease Core Centre to consider intrinsic and extrinsic motivators in a specific workforce of caregivers in specialist dementia programmes. The study examined the variables that made up the intrinsic and extrinsic motivators using a series of Chi-squared tests and *t*-tests of associations. They reported that enhancing intrinsic factors had a more positive influence on caregiver job satisfaction than enhancing the extrinsic ones. The intrinsic factors were also less costly to implement. This is relevant to the research in this thesis as it suggests that implementing intrinsically motivating strategies to improve workplace engagement of caregivers will be less costly than considering the use of pay increases (an external motivator) to increase motivation. Although the study by Drebing et al. was limited to a specific international workplace setting, it did address issues relevant to the New Zealand caregiver workplace. The effect of extrinsic motivators is being experienced in New Zealand currently, as a pay increase for ARC caregivers in 2017 has added financial pressure to the sector as other workforces also request increases. The New Zealand health sector is continuously under financial pressure; therefore, improving understanding of how intrinsic motivational factors influence workplace engagement without adding undue additional costs would potentially be of significant value.

In summary, the concept of two-factor motivation theory underpins this thesis. While both intrinsic and extrinsic factors are important for motivating people who work in healthcare services, this thesis specifically focuses on considering intrinsic factors that can be more easily controlled by individual workers and impose less cost on the sector. Extrinsic factors such as pay rates, discussed in the background chapter, and identified by Travis, (2017), are relevant but are not the focus of this thesis.

## 2.4 Job satisfaction: an intrinsic factor in workforce motivation

Job satisfaction has been of interest to researchers concerned with understanding human behaviour in organisations and the large body of literature has been summarised in a review by Spector (1997) of the key aspects of job satisfaction as a source of workplace motivation. This paper defined job satisfaction as an idea that is concerned with the meaning people derive from their work and how workers feel about the work they do. The review by Spector (1997) covered the identified factors of relationships with co-workers, appreciation by managers, communication with colleagues, future job prospects, and organisational policies and procedures.

The issue of motivation and how job satisfaction might influence the retention of employees in the health sector is of high importance to the entire ARC workforce. As noted in Chapter One, the demand for ARC services may outstrip workforce supply in the future and staff retention is one method of maintaining the sector workforce. As caregivers make up the bulk of the ARC workforce it is important to understand what role job satisfaction plays in the motivation and consequently the retention of ARC caregivers. Overall, the literature discussing job satisfaction and healthcare workforces is extensive. Although motivation and job satisfaction have been explored in depth in the nursing workforce (Coomber & Louise Barriball, 2007; Lu, Barriball, Zhang, & While, 2012; Lu, While, & Louise Barriball, 2005) these studies focused on nurses in acute or general nursing settings. Literature examining motivation and job satisfaction in nurses providing care in ARC, and indeed caregivers in ARC services, is limited.

Understanding the factors that give job satisfaction often uses measures such as regular surveys within organisations to determine self-reported employee satisfaction with the workplace. This approach is used routinely in ARC with staff satisfaction surveys mandated for the accreditation process, conducted by accredited audit agencies as part of the certification process as required by the Health and Disability Service (Safety) Act 2001. All ARC facilities must demonstrate that they have conducted an annual staff satisfaction survey to continue to provide residential care services. This process often includes identifying issues that can be addressed to improve satisfaction and, specifically, actions to address staff retention and organisational reputation. The surveys are not standardised, and each facility has a different approach to deciding what action to take in order to address any issues that might be identified. A weakness in this process is that, for ARC facilities in New Zealand, the assessment for passing the audit is that the survey has been completed, and not that there is an action plan, or that the results of the surveys have been evaluated.

From the extensive literature discussing job satisfaction and healthcare workforces, articles deemed relevant to the ARC workforce or sector were selected from the identified literature based on the search strategy concepts outlined in section 2.2. These papers are summarised in Table 2.1 and then synthesised in section 2.4.2. In summary, three key ideas emerged from the review of the identified literature– (1) the dichotomy of high job satisfaction but low intent to stay; (2) the impact of models of care on job satisfaction; and (3) differing methodological approaches to researching job satisfaction.

### 2.4.1 Summary of identified literature on employee engagement relevant to ARC facilities

The papers identified are summarised in Table 2.1.

**Table 2.1:** Identified literature relevant to exploring job satisfaction for aged care workers

| Author and country of origin | Title | Subject | Main findings | Relevance to this thesis (highly relevant; relevant; indirectly relevant) |
|---|---|---|---|---|
| Chou, Boldy, and Lee (2002) Australia | Measuring job satisfaction in residential aged care | The use of reliable measures to understand to measure staff satisfaction in ARC (*N* = 983 participants in 70 facilities). | The "Measure of Job Satisfaction" tool shown to be valid and reliable instrument for assessing job satisfaction in ARC. | Indirectly relevant – Research is relevant to ARC workforce but uses a specific measure of the wider concept of job satisfaction for all staff, not just job satisfaction for caregivers. |
| Coomber and Louise Barriball (2007) UK | Impact of job satisfaction components on intent to leave and turnover for hospital-based nurses: A review of the research literature. | Identification of aspects of job satisfaction that influence turnover and retention of hospital-based RNs. | Work environment, particularly at ward level, is important for improving turnover rates for this workforce. Leadership, educational attainment, pay and stress, with stress and leadership having the most impact on level of dissatisfaction and intent to stay. | Indirectly relevant – Does highlight the importance of qualitative methodologies such as action research in understanding job satisfaction but is specific to hospital-based RNs. |

| | | | | |
|---|---|---|---|---|
| Drebing et al. (2002)<br>US | Professional caregivers for patients with dementia: Predictors of job and career commitment. | Exploring which factors can assist in the prediction of levels of job stability in caregivers in residential dementia care (*N* = 77). | Caregiver's commitment to their job is most closely related to their level of involvement in the interpersonal aspects of the work. | Relevant – Supports the importance of the use of a "person-centred care" model of care on job satisfaction but limited by reliance on self-report questionnaires and is based in a dementia specific service. |
| Edvardsson, Fetherstonhaugh, McAuliffe, Nay, and Chenco (2011)<br>Australia | Job satisfaction amongst aged care staff: exploring the influence of person-centred care provision. | Exploring the relationship between person-centred care and job satisfaction for ARC staff. (*N* = 297). | The use of a "person-centred care" model of care in ARC can positively influence job satisfaction and consequently build a more competent and stable workforce. | Highly relevant – Explores the relationship between models of care and job satisfaction and the overall importance of this for workforce retention. However, the study includes all ARC staff and is not specific to caregivers. |
| Lu et al. (2012)<br>UK | Job satisfaction among nurses: a literature review | To update a 2005 systematic review on the issues relevant to understanding recruitment and retention issues for RNs. | Identified that the lack of any established model to explore the impact of job satisfaction for nurses on issues such as recruitment and retention has implications for the development of strategies to address these issues. | Indirectly relevant – Useful summary of a wide body of literature but directly relevant to RNs, not caregivers in ARC. |

| | | | | |
|---|---|---|---|---|
| Martin (2007) Australia | Good jobs, Bad Jobs? Understanding the quality of aged care jobs and why it matters. | Job characteristics of Australian ARC workers and compared to the total Australian workforce using surveys of facilities (*N* = 1800) and a sample of staff (*N* = 6000). | Aged care roles are not "bad jobs" but do have high turnover rates. Intent to stay is influenced by job satisfaction and job satisfaction is impacted by the experience of caring. | Indirectly relevant – Reports on job satisfaction elements in ARC caregiver workforce but relies on secondary data and indirect comparisons. |
| Morgan, Dill, and Kalleberg (2013) US | The quality of health care jobs: can intrinsic rewards compensate for low extrinsic rewards? | Exploration of the job quality of front-line health care workers to using three data sources; survey (*N* = 1006), focus groups (*N* = 31) and organisational surveys (*N* = 25). | Both intrinsic and extrinsic factors are predictors of levels of job satisfaction. Extrinsic factors are specifically relevant in understanding intent to stay and intrinsic factors are relevant to understanding job satisfaction. | Relevant – Considers motivational factors for front-line workers delivering direct health care but not specifically caregivers, so may not be generalisable to this specific workforce. |
| Wallin, Jakobsson, and Edberg (2012) Sweden | Job satisfaction and associated variables among nurse assistants working in residential care. | Job satisfaction and other variables for nurse assistants in ARC (*N* = 225). | The existence of a caring climate and personalised care provision positively influences job satisfaction in ARC. | Highly relevant – Relevant to the thesis topic but is a Swedish study so may limit generalisability to New Zealand context. |

### 2.4.2 Synthesis of identified literature on job satisfaction in ARC/health

Three ideas emerged from the identified literature. The first is that the relationship between accounts of high levels of job satisfaction but low levels of intent to stay in ARC employment seems to be contradictory. The second idea is that promoting the use of person-centred models of care can enhance job satisfaction. The third idea is that in researching this area of job satisfaction for health care workers, it is important to have reliable tools to measure job satisfaction. Related to this third idea is the more specific aspect of considering the use of qualitative methodologies to develop understanding of caregiver workplace experiences.

The first idea can be summarised as the relationship between job satisfaction and staff retention. This concept is relevant to the specific ARC workforce as the demand for services in the future may outstrip supply of labour (Badkar et al., 2009). This could potentially leave residents in ARC without enough carers to provide services for them, or ARC providers having to reduce bed capacity because of insufficient staffing. This workforce also poses a dilemma in that while they do describe high levels of satisfaction, they also indicate low levels of intent to stay. This manifests as high staff turnover. In their research using postal, fax, and email surveys to all ARC facilities in New Zealand Kiata et al. (2005) reported a staff turnover rate of 22% per annum for ARC caregivers in New Zealand. Any turnover is costly in terms of recruitment and disrupted services to residents and has been widely discussed in management literature as a factor that needs to be managed, as it can be negatively linked to organisation performance (Meier & Hicklin., 2008).

The issue of the apparent contradiction between the acknowledgment of job satisfaction and the lack of willingness to stay in healthcare employment was explored in a study by Morgan et al. (2013) in the US. This multi-method study focused on healthcare workers and used three data sources. Survey data was collected from 1006 workers in 25 health care organisations who were participating in a process to build relationships with educational institutions to develop career paths for staff. These staff members were asked to respond to a series of questions about a range of variables exploring intrinsic (e.g., supervisor support and input to tasks); and extrinsic (e.g., financial rewards, promotional opportunities) motivational factors. Additional quantitative survey data was collected from key organisational sources including human resource personnel, and qualitative data was collected from 31 focus groups. The initial surveys were analysed to examine the relationship between job satisfaction and the intent of workers to stay in healthcare employment with extrinsic job characteristics, for example, financial rewards, and intrinsic job characteristics, for example, meaningful tasks.

They found that intrinsic factors such as having meaningful tasks or supervisor support predicted job satisfaction.

> It's like family here with [administrators] and, and I know my boss, there's support everywhere. So you can go absolutely and make more money somewhere else but then you leave the support and so it's a catch 22(Morgan et al. 2013 p. 815)

In comparison the factor of "Intent to stay" was predicted by extrinsic job characteristics, with 70% of the respondents indicating that they either agreed or strongly agreed that the front-line caregiver job was not intended as a permanent vocation, but rather as a stepping stone to other jobs with that employer, for example, housekeeper – or better-paying jobs, for example, certified nurse assistant. This study explored the tension between job satisfaction and intent to stay, as workers described that they considered leaving their jobs for higher paying ones despite finding front-line healthcare work meaningful. This study suggested that although a predictive factor, simply increasing pay would not be enough to address turnover. Intrinsic factors such as supervisor support must also be present to ensure the retention of a front-line workforce. In summary, this research argues that both intrinsic and extrinsic factors need to be addressed to encourage job satisfaction and reduce staff turnover.

The relevance of this study by Morgan et al. (2013) for enabling a better understanding of the New Zealand context is limited by the sample and the international setting. The participants were front-line healthcare workers in a general sense rather than specific workforce groups, for example, direct care givers versus administrators. Job satisfaction in these other jobs could be influenced by different factors, for example, if the relative pay rates are higher. In addition, the legal, educational, and political framework in the US is different to New Zealand, and consequently it is difficult to generalise the results of this study to the New Zealand caregiver workforce. This US study suggested that factors which make these jobs "good" jobs, for example, caring work, may compete with factors that make them "bad" jobs, for example, relatively low pay rates. The balance of these competing factors seems likely to influence staff turnover. Exploring these factors is useful to understand workforce motivation issues but would be more pertinent to this thesis if focused on a specific and relevant environment. Further research of ARC caregivers in New Zealand could improve our understanding of the impact of intrinsic or extrinsic motivational factors in their workplace.

A paper by Martin., (2007) explored the idea that paid care work is an important part of the national workforce and yet is often considered a "bad" job in terms of pay, employment

conditions, and training opportunities. This study of job satisfaction and turnover in an Australian workforce provided insight into what makes “good” or "bad” jobs. An employee survey asking about employment conditions and opportunities for professional development was sent to caregivers in ARC, (referred to as personal carers in Australia) obtained from a large sample of 1800 facilities and 6000 workers. Response rates were 60% for facilities and 40% for employees. The survey results were compared to data from the Australian Department of Statistics about people determined by the researcher to be in similar jobs, that is, low paid, irregular work hours, limited training opportunities, and insecure tenure. These workers were not specified in the research by job title but were comparable in educational level, job tenure, job security, and pay, which were described as being “characterised by poor quality on all of these measures” (Martin., 2007, p. 186).

Martin’s study found that in comparison to the wider Australian labour market, ARC caregivers were paid less but had similar employment conditions and good opportunities for training; they also seemed to have similar levels of job satisfaction. Having established that these were not “bad jobs” in the sense that they shared several characteristics with similar jobs in the wider Australian economy, an analysis explored the relationship between job retention and job satisfaction for these workers. Staff turnover in the Australian ARC workforce was described as being high with 20% of nurses and 25% caregivers being replaced annually. The analysis identified that 72% of caregivers and 75% of nurses intended to be with the same employer in three years’ time. The factors that influenced this intention were employment arrangements (such as shifts and experience of work, for example, job satisfaction); personal factors; and organisational characteristics (e.g., location and size of facility). It could be inferred that if these factors were not addressed then the intention to stay in the job might change.

In summary, although the respondents in this Australian study may have been assumed to be in “bad jobs” regarding pay and employment conditions, results suggest that this was not the case. Furthermore, rather than increase the supply of labour to ensure that there is a workforce to deliver these services, the more pressing issue is to address factors that influence retention of the workforce, which includes job satisfaction. The workplace context in New Zealand is likely to be similar to that in Australia but there is a limited amount of research in New Zealand that can confirm this, beyond demographic description of the ARC caregiver workforce. The study by Martin has some limitations as the data set is now over 10 years old, and the origin of the wider workforce data is not clearly described; nevertheless, the findings

broadly support need for research proposed in this thesis: “In short, it is a safe bet that paid care work will offer significant and growing employment opportunities for many years to come” (Martin., 2007, p. 184).

A second idea emerging from the review of identified literature can be summarised as the importance of the use of a “person-centred care” model of care in influencing job satisfaction for the ARC workforce. The aim of a study by Edvardsson et al. (2011) was to understand the degree to which a person-centred model of care was associated with job satisfaction and whether it could be a predictor of job satisfaction in ARC workers. This quantitative study used data from a questionnaire completed by 297 residential aged care staff from seven facilities in Victoria, Australia. The two questionnaires used were the Person-Centered Care Assessment tool ( Edvardsson, Fetherstonhaugh, Nay, & Gibson, 2010) and the Measure of Job Satisfaction. The latter has been shown in a separate study to be a valid and reliable tool to measure job satisfaction (Chou et al., 2002). The survey had a response rate of 59% (297/500). The demographic profile of participants in this study was similar to the ARC workforce in New Zealand, with 80% female participants, 61% aged over 40 years, and the majority (55%) having roles as personal care workers.

The study reported that “perceived person-centered care was significantly associated with job satisfaction in staff” (Edvardsson et al., 2010, p. 1209). The causal relationship implied by this association is relevant for how work is organised in the caregiving job, which is often focused simply on tasks and routines and allows little time to spend with residents. Developing strategies to enable staff to spend time developing a person-centred care approach will in turn impact positively on levels of job satisfaction. This, as noted by the researchers, could require a move away from the predominantly task focused way of working to having more opportunity to spend time delivering personalised care; that is, flexible and supportive management style, and environments. The analysis found that job satisfaction was greater amongst those with the least tenure. This may suggest that the positive impact on job satisfaction from person-centred approach can become eroded with time spent at work. This research also linked job satisfaction to quality of care and workforce retention: “There are challenges in attracting and sustaining competent and stable workforce in aged care, and key issues of concern such a low staff job satisfaction and feeling of not being able to provide high quality care have been described” (Edvardsson et al., 2010, p1205).

This Australian study is relevant to the thesis question because the study sample was from a workforce providing aged care services similar to those in New Zealand. The generalisability

of the findings, while relevant, may be limited by the sample selection, which included all workers who delivered person-centred care: not just caregivers.

Another study that has explored variables associated with job satisfaction for caregivers working in residential care was reported by Wallin et al. (2012). In this study the authors report their findings from a sample survey of 312 Swedish nurse assistants in general residential or specialised dementia care (69% response rate). The survey used two tools to measure the results; firstly the Person-Centered Care Assessment tool – which evaluates the extent to which staff in residential care perceive the care provided as person-centred (David Edvardsson, Fetherstonhaugh, et al., 2010) – to measure the degree to which the working environment was person-centred. Secondly, the Person-Centered Climate Questionnaire – which measures the degree to which staff demonstrate values and behaviours that are person centred (David Edvardsson, Koch, & Nay, 2010) – to measure the caring climate of the workplace. In a statistical model predicting overall job satisfaction, feeling physically exhausted and feeling worried and restless were negatively associated with job satisfaction and personalised care provision, and a caring climate was linked to job satisfaction. The overall R-squared for this linear regression model was modest at 36%, with an implied multiple regression coefficient of 0.6. However, the strength of individual associations was not reported except by *p* values associated with the regression coefficients; $p < 0.001$ for the association with personalised care provision.

The results of this Swedish study may be difficult to generalise to New Zealand, which has different legal and policy frameworks. Although the researchers themselves report a good response rate, this was in fact only 69% so that non-response bias may influence the strength of these associations. For example, those who are less motivated to respond to questionnaires may also be less motivated at work. However, this study supports the idea that further research is needed to develop better understanding about how person-centred care in New Zealand could be relevant to supporting job satisfaction, and job retention, for ARC caregivers in New Zealand.

The importance of intrinsic factors, such as job commitment, for caregivers in residential care is also supported by research by Drebing et al. (2002). This study explored the issue of high turnover rates in ARC and how they might be influenced by extrinsic factors, for example, pay and benefits; and intrinsic factors, for example, quality of relationships with residents and families. The analysis was based on an anonymous questionnaire sent to 122 caregivers in specialist dementia care programmes, with a response rate of 77/122 (63%). The association

between job commitment, measured, for example, by a "Yes" response to the respondent thinking about quitting their job and their pay, measured in $10,000 increments, is not explicitly reported; however, based on a table in the results section of the study (Table 4), and correcting an arithmetic error in one of the cell counts, the odds ratio (estimated by logistic regression) of giving a "Yes" response per $10,000 extra pay was 0.86 (95% CI [0.61] [1.21]), $p = 0.38$. The authors did report being able to detect associations between higher job and career commitment and higher intrinsic rewards, for example, contact with families and residents. Although it is unclear from the published paper how a *t*-test was relevant to assessing the association between the ordinal scaled hours or work and the dichotomous variable about a "Yes" response to thinking of quitting, the authors report a correlation coefficient for an association of -0.24, ($p < 0.05$). This was possibly based on using a four-point Likert scale for the likelihood of quitting and using this as a predictor in a linear regression. The authors also report job and career commitment were negatively associated with higher levels of burden, measured by the Professional Caregiver Burden Index (which is a 12-item instrument that measures the burden of work of caregivers working specifically with dementia patients), with a moderate association, correlation coefficient -0.50,( $p < 0.001$). Non-response bias again could have been a problem with this study if less motivated workers did not participate in the survey. The authors reported many statistical tests, some of which may not have been appropriate to the data, and have reported a selection of positive findings, which could lead to a reporting bias. However, the reported findings support the importance of developing strategies to address intrinsic factors, for example, job satisfaction, as these are less costly interventions for developing a more engaged workforce compared to extrinsic factors, such as pay.

The third idea that emerged from the identified literature is about the way research is approached for this area of research inquiry. Most studies of job satisfaction use questionnaires or other specifically designed tools that quantify opinions and self-reported behaviours. Literature was sparse that identified qualitative research to triangulate these findings and confirm the sorts of instruments used to capture relevant concepts in studies that explored caregivers' experiences and perceptions of their workplace.

A study that attempted to put these types of instruments on a sound psychometric footing (although not through qualitative techniques) was reported by Chou and colleagues (2002). This study explored "how" a specific tool measured job satisfaction for staff working in residential age care. The study participants were selected using a stratified random sampling

approach, resulting in a sample of 983 staff from 70 facilities in Western Australia with a response rate of 57%. The tool analysed was the Measurement of Job Satisfaction Tool, which has been used in community settings, and the authors examined elements of its performance in ARC. The tool consists of 38 questions answered using a five-point Likert scale. A principle components analysis identified eight components with eight values greater than one to explain 64% of the total variance; however, only five factors had more than two questions contributing to them and the authors nominated these as: Personal satisfaction, Workload, Team spirit, Training, and Professional support with team spirit. In a simple descriptive analysis of these factors 'Team spirit' contributed most to satisfaction with a mean score of 4.2/5 and 'Workload' the least, with a mean score of 3.1/5. Although this study was concerned with the measurement properties of a particular instrument it seems reasonable to consider that there may be other important concepts not captured by currently designed questionnaires that might be identified by qualitative exploration. One such approach is participatory action research (PAR), which in turn could give deeper insight into how ARC caregivers experience their work and consequently into the development of strategies to improve motivation.

In terms of other relevant literature identified, a systematic review by Lu et al. (2005) included studies of job satisfaction in the RN workforce. The literature was sourced through a range of electronic databases including CINAHL (1982-2004), Medline® (1966 – 2004), Psych INFO® (1974–2004), British Nursing Index (1985–2004) and some Chinese databases, for example, China Academic Journal (1985–2004). Seventy relevant publications were identified. The authors indicated that they included any literature that combined the terms “job satisfaction” and “nurses” and excluded any research where the data analysis was unclear. A number of tools were used in the identified literature, which aimed to capture quantitative data in relation to factors influencing job satisfaction. In summary, the authors reported in table form which studies met the definition of job satisfaction and the identified sources of job satisfaction, for nurses. The literature they identified explored three distinct areas relative to job satisfaction. These were: sources of job satisfaction; the effect of job satisfaction on job retention; and other factors such as stress that affect job satisfaction. They reported that specific factors have a negative impact on levels of job satisfaction for nurses. These included reduced quality of workplace relationships, holding a tertiary qualification, and unfulfilled expectations of the role. They also reported that despite a range of methodologies and ways of describing the issues their conclusion was that there was no (at the time of publication) consensus about a particular model to assist in designing and

implementing strategies to address job satisfaction and related issues. This finding also supports a qualitative approach to this issue to put further questionnaire development on a firmer footing.

Another systematic review by Coomber and Louise Barriball (2007) explored the literature on job satisfaction and nurses with relevance to staff retention. They searched three databases (British Nursing Index, CINAHL, and Psych INFO®) using key words 'nurses', 'job satisfaction' and 'retention' within the years 1994–2007 and found nine relevant publications. The key ideas that influence staff retention identified from the review of this literature were leadership, educational attainment, pay, and stress" (Coomber & Barriball, 2007, p. 300). These themes provided a framework for their analysis from which they concluded that these four aspects could provide potentially easier opportunities for interventions to address issues of retention than demographic aspects, for example, age, education, and tenure. The authors recommended that further exploration was needed of factors that affect retention, particularly in developing strategies to address these issues for future health service delivery. Of specific relevance to this thesis, they also suggested that more study at ward level (actual service delivery level) could add to the depth of understanding and that the use of "more appropriate techniques such as qualitative interviews or action research may be employed to gain detailed insight into which components are of importance to particular workforces" (Coomber & Barriball, 2007 p. 312). The use of action research as a methodological approach to research the experiences of ARC caregivers is described Chapter 4, which details the PAR study central to this thesis.

## 2.5 Employee engagement: an intrinsic factor that can influence job satisfaction

The concept of employee engagement describes the degree to which an employee is committed to their job and is a significant factor in developing a deeper understanding of workforce motivation and specifically the influence on job satisfaction. Research into employee engagement tends to explore the impact of engagement on business or organisation outcomes. A key piece of work in employee engagement is a review of Gallup studies conducted by Harter, Schmidt, and Keyes (2003). Gallup researchers have studied workplace engagement for over 30 years to explore how it might affect business outcomes. Through the use of qualitative and quantitative studies in a range of workplaces they developed a 12 question survey (Q12), known as the Gallup Workplace Audit in the 1990s, which is used internationally to record and track how workplace engagement affects the efficacy of a workplace (Buckingham & Coffman, 2014). Results from organisations using the survey are

collated and reported on regularly (Harter, Schmidt, Agrawal, & Plowman., 2013). This Q12 survey is used in organisations to measure the level of engagement in the workplace and enable managers to take positive action to improve it. While there is little information about the validity and reliability of this tool published in international peer-reviewed journals, the Q12 is used in this study, not as an outcome measure, but rather as a basis for semi-structured focus group meetings. The aim of the work by Gallup was to explore whether there was link between workplace relationships and work performance, in a general employment context. They stated that:

> Employee engagement (a combination of cognitive and emotional antecedent variables in the workplace) generates higher frequency of positive affect (job satisfaction, joy, fulfilment, interest caring). Positive affect then relates to the efficient application of work, employee retention, creativity, and ultimately business outcomes. (Harter et al., 2013, p. 2)

The paper concluded that workplaces where employees are engaged in their work have more positive business outcomes in terms of customer satisfaction. They described a state of well-being in the workplace as affecting workers' ability to do a good job. By enabling the workforce to have freedom to do what they know is right, and providing good support and clarity of expectations the employees are engaged.

One limitation of this study is that little information about the validity and reliability of the Gallup tool is published in international, peer-reviewed journals, which suggests a lack of scientific evidence on the measurement properties of this tool. However, the Gallup organisation regularly conducts and publishes internal reviews and reports on the validity and reliability of their tool. While there is a lack of scientific evidence to support the measurement properties of this tool it can be used to provoke a rich, interesting discussion.

### 2.5.1 Summary of identified literature on employee engagement in healthcare services

The papers identified are summarised in Table 2.2.

**Table 2.2:** Identified literature relevant to employee engagement in healthcare services

| **Author and country of origin** | **Title** | **Subject** | **Main findings** | **Relevance to this thesis (highly relevant; relevant; indirectly relevant)** |
|---|---|---|---|---|
| Callicutt, Norman, Smith, Nichols, and Kring (2011) US | Building an engaged and certified nursing workforce. | Six tenets were developed from engagement theory. Strategies to address these tenets were implemented to increase professional certification (a process that defines a speciality scope of practice) rates for RNs in cardiac care setting. | Nurse leaders, staff-led study sessions (teamwork), career opportunities, and recognition play a key role in building engagement in this workforce as measured by increased rates of certification, e.g., from 13% to 37% in cardiac critical care department. | Indirectly relevant – Shows how staff engagement can increase professional standards, but a very specific workforce with no information on the size of the study. |
| Simpson (2009) US | Engagement at work: A review of the literature | A systematic review of research into workplace engagement of the nursing workforce. | Shows a need for a consistent definition and measurement of engagement, specifically nursing engagement, and for future research to explore how nurse engagement impacts on organisational outcomes especially indicators of quality care. | Indirectly relevant – Provides a broad overview of the state of knowledge about workplace engagement, but for the nursing workforce; not caregivers. |

| | | | | |
|---|---|---|---|---|
| Tellis-Nayak (2007)<br>US | A person-centered workplace: The foundation for person-centered caregiving in long-term care. | Certified Nurse Assistants and residents' families in 156 nursing care facilities (*N* = >10000) | Management approach and work environment, i.e. using person-centred models of care are predictors of workplace engagement and quality of care. | Indirectly relevant – Provides an understanding of the role of managers and person-centred models of care in building workplace engagement for nurse assistants. The use of survey only data and the US context may limit the generalisability of this study. |
| Warshawsky, Havens, and Knafl (2012)<br><br>US | The influence of interpersonal relationships on nurse managers' work engagement and proactive work behaviour | Nurse managers' work performance and relationships in acute care hospitals (*N* = 323). | Relationships with nurse administrators were key predictors of work engagement and relationships with physicians were predictive of proactive work behaviour. | Indirectly relevant – Highlights the importance of relationships in improving building workplace engagement, but for data from nurses in an acute care setting; not caregivers in ARC. |

### 2.5.2 Synthesis of identified literature for employee engagement in healthcare services

The aim of this thesis is to develop a better understanding of the factors that may encourage ARC caregivers to be motivated and engaged in their work. This section specifically discusses employee engagement as a motivational factor for a workforce. The literature identified research that addressed workplace engagement for the nursing workforce, but little research specifically focused on ARC caregivers. Two ideas emerged from the four studies on employee engagement that were identified. Firstly, overall little literature explores healthcare employee engagement in the workplace, especially when focusing on the caregiver or nursing workforces. The second idea that emerged highlights the importance of relationships in enabling workplace engagement.

Only two studies were identified that looked at healthcare employee engagement in the workforce that are relevant to the New Zealand ARC setting. The first is a systematic review by Simpson (2009), which explored studies into the nursing workforce and its engagement in the workplace in the US that included any literature on nursing engagement. The inclusion criteria for this review were very broad; studies in English that considered nursing engagement in any clinical work setting. Four electronic databases (CINALH, Medline®, ABI INFORM and Psych–INFO®) were searched for studies published between 1990 and 2007. Twenty publications were included for the review on the basis that they demonstrated findings that discussed "the antecedent and consequences of engagement at work" (Simpson, 2009, p. 1014). The selected literature was presented in a table that described each study by author, purpose, research setting, method of analysis, and findings of each study. The analysis identified four constructs of engagement; personal engagement, burnout/engagement, work engagement, and employee engagement and gave details about how these were defined and what tools were used to measure them (Simpson, 2009., p. 1018). The measurement tools included: For personal engagement, the 14 item scale developed by May, Gilson, and Harter (2004); for burnout/engagement, the Maslach Burnout Inventory; for work engagement the Utrecht Work Engagement Scale; and for employee engagement, the Gallup Work Audit. The Gallup Work Audit measurement tool is described in detail in Chapter Three of this thesis as it was included in this initial study. Analysis of data from these four areas indicated that engagement at work could influence personal work performance and patient outcomes. Simpson concluded a consistent way of defining and measuring engagement for the nursing profession was needed, with attention given to specific settings, for example, acute care, and long-term care. This study noted that definitions of engagement often overlapped, which

limited better understanding of the construct engagement (Simpson, 2009, p. 1021). She argued that a clearer definition of the construct of engagement was needed before being able to make reliable causal links about its impact on the nursing workplace. The systematic review by Simpson was clearly described, but identified a limited amount of empirical data, which would make the conclusions hard to generalise. In addition, this research does not indicate the presence of second reviewers for data extraction, which could limit its trustworthiness. However, it did support the notion that there is only limited research exploring the issue of employee engagement for nurses or caregivers. In summary, Simpson identified that areas for further research could include the role of nurse leaders in workplace engagement, the link between quality health care outcomes and workplace engagement, and the relationship between nurse education and workplace engagement.

The second idea emerging from the identified literature indicated that interpersonal relationships are important factors in encouraging workplace engagement. Warshawsky et al. (2012) studied the effect of interpersonal relationships on nurse managers and their work. Data were collected by self-administered electronic survey from 323 nurse managers in acute care hospitals in North Carolina, US, who were recruited via email addresses. The data were analysed using three measurement tools – the Relational Coordination Scale, the Utrecht Work Engagement Scale and Proactive Work Behaviour Scale. In summary, the respondents in this study were mostly white, female, usually with a tertiary qualification, with a mean age of 47 years and around nine years in nurse-management roles. After detailed analysis using the three tools the researchers reported that the interpersonal relationships between nurse managers and nurse administrators were key predictors of engagement at work, while the interpersonal relationships between nurse managers and physicians were predictive of proactive work behaviour. They interpreted these data to confirm the importance of the nurse manager role in creating motivating workplace environments that influence quality of patient care and they sought to understand how interpersonal relationships might influence their performance. Based on their model of workplace engagement the authors reported that job resources, which include interpersonal relationships; and job demands, including span of control both influence workplace engagement. The limitations of this study were that the methodology used convenience sampling, which may not have made the findings generalisable, and it relied on self-reported data, which could have contributed to bias. However, it did suggest that exploring interpersonal relationships in the workplace could increase understanding of the factors that encourage workplace engagement, which is a

motivational factor. This study did not consider the caregiver workforce but did suggest it could be an area for further research as described in this thesis.

The second study of relevance to this idea that relationships are important in understanding employee engagement focused on nurses in cardiac care Callicutt et al., (2011). This study involved reporting outcomes following the implementation of a strategy to improve professional certification rates in a group of cardiac nurses. In this context, professional certification is a process in which RNs are assessed for specialist skills and knowledge, similar to the New Zealand Nursing Council practising certificate, but for a specific body of knowledge (cardiac care in this study), not a general area of practice.

The study aimed to improve the rates of certification for nurses in cardiac departments. It employed a framework consisting of six tenets based on employee engagement literature. These were: (1) Establishing greater meaning to work, (2) Communicating a shared vision, (3) Encouraging decision making, (4) Creating a sense of team, (5) Enhancing career opportunities, and (6) Rewarding success. The leadership team designed strategies around each of the six tenets to engage the nurses to achieve certification. The results showed increased rates of certification in every cardiac department, for example, from 13% to 27% in critical care (30 of 82 eligible nurses had achieved certification status) and from 6% to 28% in telemetry (28 of 99 eligible nurses). The researchers described key factors that they believed were important in the success of the strategies, which included the role of the nurse leaders in communicating a vision, and the peer-led study groups, which helped with team development. Both these factors focus on interpersonal relationships that influence employee engagement in the workplace. Limitations of the study were that it was not clear how participants were recruited, the small sample size, and the impact of the relationship between respondents' decisions to pursue certification and decisions to engage in the survey. This study also did not include a control group, making it difficult to be certain about the relationship between the elements of the leadership strategy and the improvements in certification rates. It is interesting to note that this study did not refer to the "Five Leadership Practices" developed by Kouzes and Posner., (2006). This model of leadership uses five similar tenets and is well known and fundamental to many leadership development programmes in a business setting. It is most often used to improve business outcomes. However, the study by Callicutt et al., (2011) suggested a link between the implementation of strategies to improve nursing engagement and improved patient outcomes. This link between strategies to improve staff engagement and

improved patient outcomes seems relevant to the research question for this thesis as a link may be able to be identified for the ARC caregiver workforce.

The third study by Tellis-Nayak (2007) identified as relevant to employee engagement considered the effect of managers in developing a person-centred care approach in long-term care facilities. The research hypothesis was that implementation of a person-centred care model would improve staff engagement and consequently the well-being of the residents. Tellis-Nayak (2007) further explored three research questions that supported a path to implementing an environment of person-centred care: (1) Do managers positively influence staff satisfaction and how? (2) When a manager positively influences staff satisfaction, does it improve employee engagement? (3) Does improved employee engagement increase the well-being of the residents? This study used two sets of data: the first from two satisfaction surveys (designed by researchers after a literature review, focus groups, and interviews) and the second from US state inspection data collected from a process similar to New Zealand's surveillance audit process in ARC. The satisfaction surveys for staff and one for residents' families were administered in 324 facilities in the South Eastern US. The average response rate for staff from facilities was 36% and for families 33%.

Tellis-Nayak (2007) reports many statistical tests for association and, in particular, only report correlation coefficients between satisfaction with various work-related experiences where a *p* value was <0.01. In the main results table these associations are ranked by the magnitude of the correlation coefficients. The strongest associations between Certified Nurse Assistance Satisfaction were with "Managers Care" and "Managers Listen" with correlation coefficients of 0.68 and 0.66 respectively (no *p* values or other quantitative estimates of association were reported). The researcher concluded that managers had a positive impact on satisfaction of the participants; for example: "Their [Certified Nurse Assistant] satisfaction with the facility stems from the concern managers have for them, their loyalty deepens as that concern grows, and their commitment strengthens when managers care for them and listen to them" (Tellis-Nayak, 2007 p. 52). He further reported that the workplace influenced job satisfaction; for example: "The way managers influence the Certified Nurse Assistants parallels the impact the work environment has on them" Tellis-Nayak, 2007, p. 52). Finally, this study reported that job satisfaction was related to the well-being of residents; for example: "The data leave no doubt that where quality of the work environment is high, Certified Nurse Assistants are more engaged and families turn into advocates for the facility" (Tellis-Nayak, 2007, p53).

Although this study made a link between the positive workplace environments in residential care and the engagement of staff, caution should be used when generalising from these results. The low response rates could lead to biased estimates of associations, potentially with the most engaged healthcare workers also being the ones most likely to complete the survey for the study. The state inspection data, related to family surveys, was for the 12 months following the surveys and may not account for any changes in personnel or practice; and finally, the surveys were not specifically designed to respond to the research questions but chosen as they were part of an already existing data set from a quality improvement process.

The use of satisfaction surveys can be problematic, as noted above and as discussed in section 2.4.2. Future research could be improved through use of qualitative methodologies to explore these issues. It is not certain that the findings from Tellis-Nayak's study are relevant to understanding the New Zealand ARC context as the study does not give detail on the type of care delivered by the "nursing facilities" or the role of the Certified Nurse Assistant, both of which may be very different from the New Zealand setting. The results did suggest that this is an area for further study and highlighted the importance of the relationships in deepening workplace engagement, especially the role of the managers and the implementation of a person-centred care model to improve care in residential facilities.

## 2.6 The New Zealand ARC caregiver workforce

Scant research could be found that explored the workplace experience of caregivers in ARC facilities in New Zealand. The research available that does focus on this workforce provides a quantitative description of demographic characteristics of the ARC sector or focuses on specific aspects of the workforce, such as the impact of education or workforce ethnicity. Despite the limited research available there is recognition of the need to develop this workforce as demonstrated with the establishment of a workforce development programme for caregivers in New Zealand (Careerforce New Zealand, 2018). This programme has been delivered via a partnership with Health Workforce New Zealand (now a department in the Ministry of Health) and Careerforce (the Industry Training Organisation for this workforce) to address some of the issues. The programme provides development strategies for the wider support workforce or kaiāwhina, not just ARC caregivers, and is a series of actions rather than published academic research. A number of reports have also been published on the caregiver workforce, one of the most comprehensive of which was conducted by Ravenswood and colleagues who surveyed the New Zealand caregiver workforce (Ravenswood et al., 2015).

### 2.6.1 Summary of identified literature on New Zealand ARC workforce and relevance to research question

The published papers identified are summarised in Table 2.3 below and do not include wider workplace reports or action in the workforce development programme, which are included in the discussion in 2.6.2.

**Table 2.3:** Identified literature relevant to the New Zealand ARC workforce

| Author | Title | Subject | Main findings | Relevance to this thesis (highly relevant; relevant; indirectly relevant) |
|---|---|---|---|---|
| Badkar et al. (2009) | Ageing New Zealand: The growing reliance on migrant caregivers | The ethnic profile of ARC caregivers in New Zealand with data from the census: 1991,1996, 2001, and 2006 | Specific immigration policies and strategies may be needed to meet the increased demand for ARC caregivers in future. | Relevant – Gives an overview of the ethnic profile of this workforce and the importance of this in understanding the workplace experience of caregivers. |
| Jorgensen et al. (2009) | The providers' profile of the disability support workforce in New Zealand. | The work environment of caregivers ($N$ = 17,910) from 420 service providers. | Caregivers can be described as a vulnerable workforce with specific areas of concern being of lack of training, low pay, and high turnover. | Indirectly relevant – Reinforces understanding of the demographic profile of this workforce but surveys the wider kaiāwhina workforce, not just those in ARC. |
| Kiata et al. (2005) | Residential care workers and residents: the New Zealand story. | All ARC facilities in New Zealand, $N$ = 845 (excludes surgical hospitals and those no longer in business). | Turnover of staff in ARC remains high and few residents are from ethnic minorities, but staff are from a wide range of ethnic backgrounds. | Indirectly relevant – Gives a comprehensive picture of the ARC workforce and residents. |

| | | | | |
|---|---|---|---|---|
| Ngocha-Chaderopa and Boon (2016) | Managing for quality aged residential care with a migrant workforce | Workplace attitudes of ARC managers and nurse managers (*N* = 16) | The care delivered in ARC by a migrant workforce is impacted by three key issues; communication and language barriers; racism by residents, families and managers; under-employment of tertiary qualified migrant care workers. | Relevant – Considered the impact of relationships, especially with managers and residents, in the migrant caregiver workplace. Limited by the aspect that the perceptions of migrant worker themselves were not collected. |
| Smith et al. (2005) | Quality of residential care for older people: Does education for healthcare assistants make a difference? | The quality of care delivered by caregivers (*N* = 15) to residents (*N* = 39) in one facility in Auckland. | Education provided for caregivers can increase the level of appropriate and adequate care provided to residents. | Highly relevant – A quantitative study that demonstrated a link between one aspect of the workplace environment (education) of ARC caregivers and quality of care for residents. Limited by the sample of one facility. |

### 2.6.2 Synthesis of identified literature for ARC caregiver workforce and relevance to research question

A review of the New Zealand literature regarding ARC caregivers assists in setting the context for this thesis by providing understanding of the demographic characteristics and factors influencing the workplace environment. Five studies were identified that provide a perspective on the New Zealand context. Most of these studies describe the demographic profile of the workforce, with one study identified that considered the caregiver workplace environment from more of a workforce development perspective, that is, the impact of education.

A study by Smith et al. (2005) considered the importance of having workforce development for caregivers, specifically education and how this influences the quality of care. The data for the study was collected from observations of 30 residents in one ARC facility in Auckland, New Zealand. The participants were observed every six minutes for one minute over 10 four-hour periods. The study used pre- and post-intervention study design, using the Quality Assessment Project tool to assess efficacy of the intervention (Norman, Redfern, Oliver, & Tomalin, 1994). This tool uses a structured observation and scoring method to assess the quality of patient care in hospital wards. The intervention was a 10-week interactive education programme. The programme was delivered in 10 one-hour sessions and covered topics such as "keeping a safe environment for residents and staff including infection control" and "keep my dignity and independence – helping a resident manage continence, washing, and dressing" (Norman et al., 1994, p. 3). Following implementation of the education programme there was an increase in the care described as "adequate and appropriate" and a decrease in the care described as "inadequate and inappropriate", based on analysis using the Quality Assessment Project tool. The researchers assume that: "Most health care assistants learn to care for these older people 'on the job' and develop their skills and knowledge from other healthcare assistants" (Norman et al., 1994, p. 2).

More recently, a follow-up survey by Ravenswood et al., (2015) analysed surveys from 266 ARC caregivers. Although the low response rate of 13% means interpreting the results with caution, the characteristics of the caregiver workforce seem to have changed since 2005 with respect to work-specific training. The survey found that 82.6% of caregivers in ARC facilities had completed at least some of the National Certificate in Health, Disability, and Aged Support from a recognised industry training organisation (Ravenswood et al., 2014). In detail, 45.9% had completed Foundation Skills (level 2); 53.2% Core Competencies (level 3) and

39.5% Residential Dementia (level 4). This confirms that the ARC workforce does undergo training. It cannot be conclusively assumed, however, that the quality of care for ARC residence increases as the level of training of caregivers improves: this assumption requires further experimental testing.

Two of the selected studies explored the issues of ethnicity in the workplace environment in ARC. Firstly Badkar et al. (2009) considered it from the perspective of increasing demand for services and a decreasing labour supply, mostly influenced by an ageing population. This policy paper used census data and immigration data from 1991 to 2006 to model future requirements for ARC, based on assumptions of trends indicated in the 2008 Social Report from the Ministry of Social Development, Wellington, New Zealand (Ministry of Social Development, 2008). Several limitations or assumptions were made, including not differentiating between residential and community caregivers, and it was noted that a key limitation of their work related to the change in the census occupational coding during the time period selected. The changes were from NZSCO90 v1.0 used in the census for 1991 and 1996, to NZSCO99 v1.0 used in 2001 and 2006. Estimates were that New Zealand will need to employ 48,200 caregivers to meet the demand for ARC services by 2036 (Badkar et al., 2009). If this cannot be met by local workforce supply then other strategies will need to be considered, including the use of the migrant workforce. To respond to the increasing need for care for the elderly, they proposed three strategies – firstly, increasing the supply of caregivers; secondly, making better use of the available caregiver workforce; and thirdly, reducing the need for caregivers. Badkar et al., (2009) concluded that their data showed there was an issue with demand and supply of caregivers, and also noted that other countries had already started to address this. For example, the Japanese government has already embarked on projects to increase the number of caregivers to meet its ARC employment needs, while the Philippines has begun adapting its educational institutions to produce workers to meet the demands of ageing populations. While relevant to the context for this thesis set immigration policy is not the focus of this thesis.

A second study by Ngocha-Chaderopa and Boon (2016) considered the quality of care implications for an increase in the migrant workforce in ARC. In this study semi-structured interviews were undertaken with 16 managers from nine ARC facilities in Dunedin. Interviews covered three areas: What are the general issues regarding employment of migrant workers? What are the management benefits and challenges of employing migrant workers? What impact do migrant workers have on the delivery of care? No detail was given on how

these questions were developed. A manual thematic approach to analysis was used from which three key themes emerged: (1) communication and language barriers; (2) perceived racism and discrimination by residents, families, and managers; and (3) under-employment of tertiary qualified migrants care workers. The first theme is summarised by the following participant comment: "In our dementia unit where residents are old and suffer from memory loss and sometimes they speak incoherently . . . communication is a big issue especially with English being a second language for most of the migrants" (Ngocha-Chaderopa and Boon, 2016, p. 7).

This comment highlights an issue for residents, but other findings indicated that communication could also be an issue for caregivers as they rely on instructions from other staff for many tasks: "You may think you have made yourself clear to them when you explain to them how work is done because some of them just nod enthusiastically . . . however when they do the job you realise they did not understand your instructions" (Ngocha-Chaderopa and Boon, 2016, p. 7).

The second finding was the existence of perceived racism from residents, families, and staff towards caregivers. This was illustrated in comments made by participants who highlighted the difficulty of managing these incidents. The researchers identified four approaches for managing these situations: asking migrant workers to ignore the abuse; reallocation of non-migrant workers to residents who express dissatisfaction; integrating migrant workers by giving them more time and opportunities to get to know residents and families; and defending the migrant worker. These were recognised as complex situations that require demonstration of high levels of management skill and ability by facility managers. It is interesting to note that there is no specific tertiary qualification or course of study for any person wanting to develop a career in ARC facility management. Most people in this role have an RN qualification.

The third finding in this study was under-employment of migrant workers. The implications for managers was summarised by the researcher's comment: "Several managers, however, did make specific links between qualification mismatch and work-related stress with migrant workers specifically" (Ngocha-Chaderopa and Boon, 2016, p 13).

While this study has an important limitation in that they it did not seek the views of migrant workers themselves but relied on the view of managers, it does suggest that the workplace environment for caregivers in ARC could be made more complex by an increasing migrant workforce. As this method of increasing the workforce seems to be a viable strategy to help

meet increasing demand for service in ARC it will be important for the sector to address this issue in future.

Two of the studies identified in this review focus on the demographic composition of the caregiver workforce. A comprehensive study by Kiata and colleagues (Kiata et al., 2005) used a survey that included all ARC facilities in New Zealand (identified by the Ministry of Health listing for licensed hospitals and rest homes and a commercial list of ARC facilities used for marketing purposes) to obtain demographic data on the facilities and staff. The aim was to provide a picture of who lives and works in ARC in New Zealand that would assist in future health service planning. The survey was tested with a pilot study in Auckland and comprised nine questions that were answered by managers. The survey was sent by post, fax, and email to 919 facilities and had a 55% response rate. The facilities had between 3 and 222 beds; 54% of these had less than 30 beds. This is consistent with most ARC facilities being small in relation to numbers of staff and residents. The facilities covered all levels of care: private hospital, rest home, and secure dementia care.

The residents in the survey were predominantly Pakeha (the other ethnicities represented were 36% Māori residents, 13% Asian and 15% Pacific) with some regional variation and most were aged 75 and over. Both registered and enrolled nurses were employed in the sector with the majority (47%) being in the age bracket of 46–60 years. As discussed previously, workforce retention is an important issue for the sector and this study indicated that 8% of these nurses were aged over 60 years, indicating likely retirement in the next 5–10 years. Caregiver profiles were slightly different compared to the nursing group, with 52% in the 25–45 years age bracket and those over 60 comprising only 2% of the workforce. The ethnic composition of staff included Pakeha, Māori, and Asian ethnicities with 15% of facilities employing Māori nurses and 64% employing Māori caregivers. In summary the data suggest the ARC sector had a resident population of mostly Pakeha, mostly over the age of 75 years, and that many facilities had an older staff population from a range of ethnicities.

This demographic profile has also been updated by (Ravenswood et al., 2015) in research that showed an increase in the age of the workforce with 23.1% over 60 years, and 40.0% aged 30–49 years. Limitations of this study were the low response rate and that the definition of nurse or caregiver did not always reflect the skill and knowledge of an individual. For example, sometimes enrolled nurses are classified as caregivers. However, the study also detailed other characteristics, for example, language spoken and time spent at work, that provided a comprehensive profile of not only those who work in ARC but also the residents

who live there. They did note that while this is useful, future research was required to ". . . further understand this evolving carer/care recipient population for effective policy development and implementation" (Ravenswood et al., 2015, p 10)

The study by Jorgensen et al. (2009) used a three phase mixed-methods study design to explore demographic characteristics, for example, training, pay rates, and gender. The three phases were (1) a general survey (developed from a literature review and providers of residential, home based and disability support services) with a 45% response rate, (2) a targeted survey of training needs with a 100% response rate, and (3) focus groups to explore the characteristics of the wider disability support workforce. They included both residential and home support workers in New Zealand selected using purposeful sampling methods. After transcription, interview and focus group data were analysed in NVivo software using grounded theory approach. The survey described a predominantly older female workforce with low educational achievement. Pay rates were low, however, and training was seen as important with 78% ($N$ = 322) of facilities funding the training they provided. In addition the researchers suggested that training was perceived by providers to influence staff turnover rates, which were 39% (it was not stated but assumed to be per annum) in home care and 29% in residential care. To support this perception the researchers commented that "Providers in New Zealand felt that some training could reduce staff turnover" (Jorgensen et al., 2009, p. 403). Reinforcing the finding that training is seen as important, 93% of providers had training programmes in place. The topics covered by these programmes are shown in Table 3 (Jorgensen et al., 2009, p 401). They detail 23 topics that include personal care, emergency procedures, infection control, lifting and handling, and falls prevention. It was noted that some of this training was mandatory, as it was required for audit by certification agencies. However, the data from all three phases suggested some key barriers to training relevant to ARC included: the lack of funding, the inability to release staff due to low staffing levels required to remain financially viable, and the lack of incentives for staff to attend. These barriers meant that although important, the training was often not well attended and consequently caregivers did not have the skills and knowledge necessary to provide the care required. This was summarised by the researchers' comment that "New Zealand does have a vulnerable workforce proving erratic care to vulnerable people" (Jorgensen et al., 2009 p. 403).

The literature identified for this section explores some of the workforce development and demographic issues for the ARC caregiver workforce. The studies identified show that while

there is research that provides an understanding of these specific aspects of caregivers' workplaces, there is potential for future research to provide a more qualitative understanding of the experience of these workers; this the focus of this thesis.

## 2.7 Summary

The aim of this thesis is to develop a better understanding of the factors that encourage New Zealand ARC caregivers to be motivated and engaged in their work providing care for frail older people. The search of electronic databases led to the identification of some relevant research, but overall there is very little empirical information about the experiences of this important workforce in New Zealand or overseas. No studies were identified that were specifically qualitative studies of motivational factors in the New Zealand ARC caregiver workforce. However, the studies identified do provide a context in which to develop research to explore the thesis question.

The selected studies on job satisfaction explored the apparent contradiction in high levels of job satisfaction but low levels of intent to stay in health services, the importance of a person-centred model of care in enhancing job satisfaction for workers in residential care, and the value of using robust models and qualitative methodologies in deepening understanding of issues experienced by healthcare workers. The selected studies on employee engagement highlighted the existence of some research into nursing engagement specifically, and more generally the importance of relationships in building an engaged workforce. These findings suggested that a more detailed understanding of workforce motivation of ARC caregivers would assist in understanding work satisfaction and performance, and could impact positively on the quality of care for residents in ARC services. The studies identified as being focussed on the New Zealand ARC workforce highlighted that workforce development for caregivers in ARC may be able to positively influence care delivery. They also gave an overview of the demographic composition of the workforce.

The following chapters describe the methods and results from two research projects aiming to address this knowledge gap. The first is an exploratory study that aimed to better understand what encourages New Zealand ARC caregivers to be engaged in their workplace. The results from this study indicated that more in depth methodology was needed. The second, PAR study, which was developed from the findings and process of the first study and which explored and tested specific strategies to encourage more workplace engagement.

# Chapter Three: A Qualitative Descriptive Analysis of ARC Caregivers' Experiences and Perceptions

## 3.1 Introduction

As previously discussed, research suggests that ARC caregivers who are fully engaged in their work are more likely to positively influence the quality of care for frail, older people. This chapter describes the initial study, which is the first piece of research in this thesis that explored aspects that encourage caregivers to be motivated and engaged in their work. This particular study was not intended to be a comprehensive qualitative study, representative of the experience of all ARC caregivers in New Zealand; instead it was intended as an initial exploratory activity to generate concepts for investigation in the subsequent research reported in this thesis. The study was designed to collect the views and experiences of caregivers in ARC facilities using qualitative descriptive methods.

## 3.2 Methodology of initial exploratory study

### 3.2.1. Facility and participant recruitment

The proposed research was presented at a monthly meeting of ARC facility managers in the Wairarapa District Health Board, which is located in the greater Wellington region. This meeting included representatives from 15 different ARC service providers, who are the only providers of ARC service in this geographical region. The managers from all these provider facilities were invited to attend the meeting, which was held bi-monthly by the Wairarapa District Health Board portfolio manager for the health of older people. The meeting involved the researcher (JP) presenting the purpose and process of the study, together with how a facility could participate. Four facilities accepted the invitation to participate in the study. Although a small number of facilities participated, this purposeful sample was chosen as it enabled detailed investigation of issues relevant to the research topic as is required in qualitative research methodology (Ritchie, Lewis, & Elam, 2013). All facilities participating in the study were given more information about the study both verbally and through a written information sheet (Appendix 1). The managers were able to ask questions at individual follow-up meetings with JP. Once a facility manager had agreed to participate in the study they invited caregivers to participate and gave them the information that was available. Caregivers were eligible to participate in the study if they were permanent staff members, willing to contribute to a focus group meeting, and had at least a conversational level of

fluency in English. Other employees, for example, RNs, cleaners, administrators, or managers, were not recruited for the research. All participants were given an information sheet, provided with an opportunity to ask any questions about the process and reminded that they could withdraw at any time and no identifying data was kept. All participants completed a written consent form before attending a focus group. Ethics approval for this study was obtained from the University of Otago Departmental Human Ethics committee (Appendix 2).

### 3.2.2 Data collection

Focus groups were used for data collection, except in one instance where only one participant was recruited from an ARC facility, so an individual interview was conducted. The times and dates for the focus groups were negotiated to fit in with shift work and to minimise disruption to the facility operations. The focus groups took place in the facility where the participants worked using a staff room or similar quiet space. The individual interview occurred in the participant's home. Each meeting started with introductions, a reminder of the purpose of the study, and an overview of how the session would be run. The meeting started with structured questions using a tool developed by Buckingham and Coffman (2014), the Gallup Workplace Audit, also known as Q12. Verbal permission to use this tool in this informal way was given by a representative of the Wellington Office of Gallup, New Zealand. While there is little information about the validity and reliability of this tool published in international, peer-reviewed journals, the Q12 was not used in this study as an outcome measure, but rather as the basis of semi-structured focus group meetings. For this reason, the lack of scientific evidence on the measurement properties of this tool is less important than whether it provoked a rich, interesting discussion. These questions were then used to encourage more in-depth, open-ended discussion by the participants. Each session ran for between 50 and 75 minutes, was audio recorded, and later transcribed verbatim. All data were collected over a three-month period and generated 38 pages of transcribed data from nine participants and four hours of transcribed interviews.

At the beginning of each focus group session participants were asked each of the Q12 questions by the researcher and then asked to rank their response on the scale by verbal indication and holding up their hand. The number of people responding to each score in the five-point Likert scale was recorded. The researcher then asked the group what prompted their response to initiate further discussion about what encourages the caregivers to be engaged in their workplace.

### 3.2.3 Data analysis

Qualitative descriptive analysis, as described by Sandelowski (2000) was used in this study to analyse the data from the focus group meetings and individual interviews. The method used was consistent with Sandelowski's view that "qualitative descriptive studies offer a comprehensive summary of an event in everyday terms of those events" (p. 336). The initial study in this thesis sought to summarise the workplace experience of a group of caregivers in ARC. After the pages of transcribed data were collected they were entered into a free software package, QDA Miner Lite (Lewis & Maas, 2007). This software was used to help identify and code issues and ideas related to the participants' experience of engagement in the workplace based on verbatim focus group transcripts. These issues and ideas were coded for meaning and relevance to the research question. Initially line-by-line analysis was used to identify common themes in the participants' talk about their views and experience of work and workplace engagement. Overlapping concepts were grouped into categories, then into core themes. The coding of concepts, categories, and themes were discussed with a thesis supervisor (WL) to explore other ways of interpreting the data and to ensure that the themes did indeed arise from the data rather than being imposed on the data. These supervision sessions supported reflexivity during the study and assisted in the iterative process of determining the identification and description of themes. The three core themes and concepts that contributed to them were also tested for relevance in discussion with the ARC managers in informal post-focus group session meetings and considered for trustworthiness by reference to the ARC experience of JP.

## 3.3 Results

### 3.3.1 Characteristics of participating ARC facility and caregivers

Four ARC facilities participated in this study, including three that provided rest home level care only and one that provided rest home and hospital level services combined. None of the facilities had a secure dementia unit. The facilities varied in size from 25 to 40 residents and were a mix of privately and national corporate owned facilities.

Nine caregivers from these facilities participated in the data collection, eight in three focus groups and one as part of an individual interview. All participating caregivers were female and all were New Zealand European. No other demographic data was collected.

Participants tended to rate their answers to the Q12 tool collectively rather than as individuals, which was a consequence of collecting these data in a public format. In response to the

request to rank a question, the participants looked to each other for confirmation of the "correct" response and appeared uneasy if they had a different response to others. A few participants occasionally chose a different response to some of the Q12 questions, and would stick to them even if it was different to others' responses, especially once they were reminded of the anonymity of their participation in the study. However, largely these data appeared to reflect group responses rather than individual responses. Consequently, reporting the Q12 data at an individual participant level did not seem meaningful or trustworthy and no analysis was done with the data collected from this part of the research process. The caregivers seemed more at ease expressing a view different from those of others in their group when they discussed their responses. This was possibly because they could qualify their views with additional comments rather than simply giving a number from the Likert scale as a response.

### 3.3.2 Overview of finding:

The initial line-by-line analysis of the verbatim comments led to a number of overlapping concepts, which were grouped into eight categories. These were: (1) opportunities to do best work, (2) interpersonal relationships, (3) having opinions that count, (4) caring about older people, (5) time to do work, (6) spend time with residents, (7) development opportunities and (8) having opportunities to talk about progress. Further refinement of these categories led to three core themes: (1) working with others, (2) having time to do the work, (3) having pathways for professional development. The data from all four focus groups were analysed without referencing the specific interview that the comment came from. Unfortunately, this meant that the verbatim comments, while representative of participants from all groups, are unidentifiable. This non-attribution of verbatim data limited the trustworthiness and ability to reference the data and is a limitation in this study. However, this process was addressed in the second PAR study when the data was analysed with reference to the meeting it was obtained from and therefore could be accurately attributed.

### 3.3.3 Working with others

The first key theme, which essentially describes teamwork, included two sub-themes, the importance of interpersonal relationships and teamwork.

> "You know we had a great team environment, and you all work together, and it was just like – wow. You know, it was really good."

Participants clearly described their relationship with other caregivers when making comments about their experience of their workplace. They described how they felt satisfied with their

work when all tasks were completed, and everyone worked well together without conflict. This was identified by all participants as an important feature of a good work environment, and often discussion around this topic had a number of nodding heads, with verbal indicators of agreement.

> "I worked before in a place where (we) stop at nine o'clock, or half past eight, just after we finished doing most of the showers, and getting up, and we stopped, and discuss what's next, what has to be done, which is really good."

When teamwork in the workplace was not satisfying for the caregivers, they did not feel they were engaged in their work. For some participants poor teamwork resulted in strong intention to leave the workplace, which illustrated how important positive interpersonal relationships were for the retention of these staff members.

> "I just think if you don't like so and so, or someone in particular, you should get out of this job."

However, other participants demonstrated an attitude of resilience, in that they could remain in the job by finding ways to cope with the behaviours of other caregivers, although this led to feelings of job dissatisfaction.

> "I wasn't going to let some girls be so mean to me that I wanted to leave."

Like many ARC facilities in New Zealand, the work of these participants was organised into groups or teams of staff who work on a shift together. These shifts covered a 24 hour period and could be between four and eight hours long. Sometimes they were asked to work double shifts, where two shift periods were worked back to back. While this was not recommended for health and safety reasons, the participants reported that this occurred when there were staff shortages. This meant that the participants could be working closely with others in their team for extended periods, with the additional burden of work-related pressure including fatigue. The participants reported that there could be between two and five staff on a shift depending on the size of the facility and the level of dependence of the residents. Participants spoke specifically about how poor relationships with others on a particular shift had a negative impact on their feelings of engagement in the work.

> "'Cause you've got to do more, and sometimes others are not willing. If you've got a couple of them [unwilling staff] on, it can spoil the whole shift. And it's really unprofessional."

> "Other times, one person, and the shift can be completely disrupted; its hard slog to get through you can't wait for it to come to the end of the shift."

Lack of teamwork on a shift clearly impacted negatively on team morale. From the comment above describing "unprofessional" behaviour it can be inferred that if caregivers have an experience of working with others who are not satisfactory, they will be less engaged in their work. Consequently, this could impact on the quality of care provided to residents.

In their comments about teamwork the participants expanded the concept to include not only how they gave support by working together, but also how they sought support. Some clearly understood that effective teamwork meant working in a way where the relationship was reciprocal: both giving and receiving support.

> "There's a few people who struggle with it [teamwork], because they've never worked very well in a team. They wouldn't have asked for help, they wouldn't need anything. Some people, they don't want anyone's help."

The participants in this study were able to express this idea of reciprocity and demonstrated a grasp of this complex concept. Their comments indicated that they knew what good teamwork looked like and the positive impact effective teamwork had on the workplace environment.

The caregivers in this study not only regarded their relationships with other caregivers as important but also their relationships with senior staff – specifically the RN in charge of the shift. One aspect they noted was an expectation that senior staff would show leadership within the team. In particular, the participants expected the RN to provide leadership when it came to managing the behaviour and contribution of underperforming caregivers. The participants reported dissatisfaction when colleagues completed their work to a poor standard, but this was ignored by RNs, which led to frustration with the lack of leadership.

> "But unfortunately, when it comes to pulling some caregivers up, the RNs don't follow through . . . I don't know if they feel intimidated, which could be right, but really, they need to deal with it when it happens."

The lack of effective performance management by RNs in turn affected those having to address the consequences of the performance issues, for example, requiring other staff to remake beds or re-shower residents. Not only did this make for additional work for other the caregivers, but also resulted in unsatisfactory care being provided to residents.

> "Well, simple cares, like washing like their face, cleaning their teeth, washing their bottom, that's, to me, is basic. Do their fingernails. Yeah, it's basic. But . . . you know

> that they haven't done it because they've all still got their flannels and tea towels – hand towels, hanging in their rooms . . . And their fingernails are black and their toothbrushes are dry."

An important task for the RN on the shift was to allocate a number of residents to each caregiver, which determines the workload for that shift. When this was well managed participants reported having a sense of equity and fairness about the workload. Conversely, the participants could experience frustration and feelings of lack of support if the allocation of residents to caregivers did not seem well managed. A consequence of this was the participants feeling less motivated about their work.

> "The RNs don't follow through but really they need to deal with it when it [caregivers not pulling their weight] happens, sort it out, and if they [caregivers] don't then they need to go home. And that doesn't happen so that spoils the day"

Essentially, the participants reported having an expectation that the RN would fulfil a leadership role within the caregivers' team. Of note, this is not unreasonable as it is part of the RN scope of practice as determined by the Nursing Council of New Zealand (2010).

Whether it was the sense of working in a constructive team, with a group of likeminded peers on the same shift or having confidence in the senior clinical person in a leadership role, positive experiences of working with others seemed to be an important part of enabling the participants to be engaged in the workplace.

> "I love this place now, but when I first started, I wasn't going to stay. Because I didn't know what I was doing and the girls on the floor, I thought they were quite mean."

Furthermore, the participants alluded to the relationship between their engagement in the workplace and the standard care delivered to the residents. They reported a sense of frustration when they could not deliver the standard of care they want to.

> "I guess the problem is, if you're feeling a bit resentful and cross with the other person, the risk is it gets transferred to the residents or you get impatient with them because you know that you've got so much else to do and no one there to help you out so you're pushing them [the residents] a bit, and that's not fair."

### 3.3.4 Having time to do the work

The second key theme described the participants' comments about the importance of having sufficient time to do a good job of the work that is required in the caregiver role.

> "And most of it's 'cause we're just passionate about elderly people and making a difference."

This included both having time to care about each resident as a person and having time available to perform the care tasks to a standard that the caregiver felt was satisfactory. When exploring the importance of having time to care about the resident as a person, the participants talked about the respect they had for their elderly residents and their desire for them to be treated well.

> "I enjoy being around elderly people. Like I care for my mum and dad as well, and you know I do have respect for the elderly. At the end of the day it's not about the money it's about the work. Which I enjoy."

The participants also demonstrated an ability to empathise with the residents' situation at a very personal level and understood what it might be like to be in their shoes. Central to this ability to empathise was the caregivers' belief that they had sufficient time as well as the skill to do the work well.

> "I know I do a good job. I do the best of my ability for the elderly . . . I treat them the way I hope, which is very scary . . . one day I'll be treated like that"

The participants identified having time to spend with residents as important in enabling them to address both the physical (providing direct personal care) and emotional (providing emotional and social support) areas of the caregiving role. Having time to deliver care in both these areas gave the participants a sense of a job well done. In essence, their pride in work was expressed as how well the resident was cared for in both these domains.

> "And you know, instead of just, you know, drying their hair quickly, I'd probably—you know try and do something nice with it, or in some cases with the ladies it would be nice to put make up on, you know, cause some of them have it. Excuse me, we just don't get the time."

This description of what physical care looks like is underpinned by a sense of empathy noted above, which arose from a very personal perspective on the caregiving role.

> "And that's what I love about care giving, I feel that I'm going to do a good deed now and look after them properly, then I'm going to be looked after properly."

While the participants talked about the care they wanted to provide and the connectedness they felt with residents, they were concerned that this could not always be achieved in the

time allowed. Time to spend with residents was important as it enabled the caregiver to develop an emotional connection with a resident; not just complete the physical task. However, it was often difficult to achieve this as the physical aspects of caregiving were usually set as the priority work task, which could leave little time to build this connection.

> "The only time that we do really get to talk to them is while they're in their room doing their care. There's no actual time to talk to them for a minute."

> "It is hard sometimes to spend that little bit of time with [the residents]. Yeah, depends on what's happening on the floor as well. Be where we need to be, you know. Yeah, it's just spending time with them; it's really quite hard sometimes. And it's sad really."

The caregivers attributed some of the lack of time on a shift to factors that were in the control of individual staff members and their approach to simply getting the job done. Some had better time management skills than others and this was essential in being able to complete all the tasks required to be done in the shift.

> "And it's also sometimes too, when like we're on a time limit. You feel the urge just to dress them. You know, like get it all over and done with rather than let them do it themselves, you know, 'cause some of them can. And that's something that we're meant to be doing . . . We've got to encourage their – [independence] . . . Sometimes I try and do a few things in the time, while they're putting a top on, I'll make the bed, and you know . . . we've got another one in the shower, and she just mucks around, and talks, and then she'll remember something so she gets her bag out and wants to show me something."

Spending time with residents seems to be indicative of an important competency for caregivers. They clearly identified those of their colleagues who did not demonstrate this caring attitude and regarded this undesirable in a caregiver.

> "Some people just don't have that caring attitude, they're like come on, get up, get dressed, have lunch I'm going home now."

> "To make the job easier for themselves [caregivers] they get through it faster and then they can sit down and watch TV or have an extra smoke."

The participants in this study expressed some strong feelings about wanting to provide good care and build effective relationships with residents, and that it was an important part of the work experience to work at the pace of the resident.

> "You can't rush them, whatever their needs are whatever is wrong with them. You've just got to be clever, haven't you?"

However, despite being highly motivated to do this there was often not enough time in the shift so they had to find other ways to achieve this. As indicated in the above comment, some participants were able to develop strategies that enabled them to have the time they needed to provide both physical and emotional care to the residents.

### 3.3.5 Having opportunities for professional development

> "You know, and really in life, or in your job, with anything, setting goals is a really good thing to do. Something to work towards."

The third theme addressed the issue of professional development in the workplace and its relevance to engagement of caregivers in ARC work. Participants discussed professional development in the context of training opportunities and performance appraisals. They suggested that they did not get as much work-related training as they would have liked and that more of this would increase their engagement in their workplace.

> "When I've worked in other places . . . the training's always been provided for you to do the job as best as you can and to further yourself . . ."

Training was valued by the participants, but in their discussions they identified several barriers to accessing training opportunities in the workplace. Some caregivers commented that there was no funding for them to receiving training, so they had to pay for it themselves. This is a significant consideration for a workforce that is low paid and where the cost of training has to be prioritised along with other household expenditure items.

> "I know there's training available and I've been on a couple of things. But what I struggle with is that there's only a certain amount that's paid for, it's like one day per year – so once you've completed your one day you have to pay for it yourself and I'm paid quite badly."

> "So once you've completed your one day you have to pay for it [additional training] yourself. And we're on a really low wage. So I struggle with that a little bit."

The timing of such programmes was identified as another barrier to accessing training opportunities.

> "Well, I was offered one but I couldn't go, because I had to work."

Some participants identified that training programmes tended to be scheduled for times that conflicted with shift work and rosters. The rosters were usually worked out in advance so training could be accommodated and staff rostered off a shift and on to a training session. However, with service that needed to be run 24-hours a day, it was at times impossible to get a training session that suited all staff unless several sessions were run, which would add cost to training delivery.

As discussed earlier the ARC workforce is mostly female older women who have family commitments. The comments below demonstrate how difficult it could be for these participants to get access training opportunities and manage their other family responsibilities outside of the work environment. Some participants had both younger children and older relatives to manage in their household. The time the caregivers had available outside of work was often already committed, which meant for them, making additional time to attend training sessions required a lot of organising, for example, after-school care or respite care for older adults – all of which could add to the cost both in dollar terms and in the personal time required to arrange them.

> "Means my kid needs to go to before and after school programmes, I've got to pay for petrol then actually going to it [training] anyway, I've got to pay for that."

This extract also highlights another barrier – the cost of travel to get to training opportunities. Many caregivers worked close to home, but there could be travel costs associated with attending training opportunities outside of work, for example, at the DHB or at another ARC facility. As noted, this was especially difficult for a low-paid workforce, however valuable they regarded training to be. Added to this, a few participants were sceptical of the value of training and could see no added value in learning about relevant topics.

> "Half the courses you go to, I find aren't beneficial because it goes over what you do every day."

However, many participants recognised that they should be encouraged to continue to learn and could see benefits of such training. The participants knew that ARC facilities were required to provide regular training for caregivers on specific topic areas. Evidence of a training plan for caregivers is a requirement for the Ministry of Health audit certification process and provides assurance that quality care is delivered to residents. Providing training was recognised by caregivers as part of the management of the facility.

> "Yeah, we do, we've had a nurse come in once a month lately to talk about pacific [specific] subjects. Yeah, like one of the recently was dementia, just dementia. And . . . it was like a seminar thing, and I thought that was awesome."

There was general agreement that performance discussions, for example, regular appraisal sessions with a manager, were useful in helping the participants understand their work role and feel valued.

> "It [performance appraisal] made me feel really good."

The participants agreed that regular performance appraisals also encouraged them to engage more in their workplace, perhaps by giving the work more meaning. However, while the participants commented that they found value in these reviews of their work, they also noted that these types of appraisals frequently did not occur.

> "I've never had one, so I don't really know the loss of not having it."

> "I feel that's one area that's lacking, there's not a lot of personal development here. And we're meant to have performance appraisals every year, and we haven't had one with our new manager."

In summary, this study resulted in three key themes reflecting a deeper understanding of the workplace experience of caregivers in ARC. The first theme described how working with others on a shift, both with peers and senior staff, can build positive interpersonal relationships, which enables better work engagement. The second theme described how having sufficient time to spend with residents gave the participants the ability to express their care for them both physically and emotionally. The third theme described the importance of professional development in encouraging workplace engagement, but highlighted how barriers exist that can limit opportunities for both training and performance appraisals. The potential implications of these findings and the connection to some of the relevant literature are explored in the following section.

## 3.4 Discussion

This first study aimed to extend understanding of what enables caregivers to be engaged in their work in ARC facilities. While this was not intended to be a comprehensive qualitative study of the experience of a fully representative sample of ARC caregivers in New Zealand, this study achieved its objective of generating concepts for exploration in the subsequent research reported in this thesis. The results from this study did not give an in depth understanding of the caregiver workplace experience. Consequently PAR methodology was

indicated as a more appropriate research design. The choice of this methodological approach to answer the research question is reported in Chapter Four.

The first theme emerging from the data described how interpersonal relationships were important in encouraging engagement, in particular the development of effective working relationships with other staff in an ARC facility. The finding that relationships are relevant in enabling engagement in the workforce is consistent with the findings of a quantitative US study that used an electronic survey of 323 frontline nurse managers in acute care hospitals to explore factors supporting a model of engagement (Warshawsky et al., 2012). The underlying model proposed that proactive behaviour and interpersonal relationships contributed to work engagement, supported by statistically significant correlations between all variables. In this study survey data from 323 nurses was analysed by three instruments that measured engagement. The authors concluded that this engagement was not limited to a specific level of relationship: "Although interpersonal relationships with peers and physicians influence nurse managers' work engagement it is the nature of their interpersonal relationships with nurse administrators that most strongly influence nurse managers' work engagement." (Warshawsky et al., 2012, p. 424)

The importance of interpersonal relationships at both peer and senior level was demonstrated by the participants in the initial study in this thesis. The participants indicated that when their experience of these relationships was constructive, they experienced a positive work environment. Most often the concept of working with others in a positive way was expressed in terms of the effectiveness of teamwork on a single shift. Experience of teamwork during shifts was identified by participants as having influence not only on workplace engagement, but also on staff retention. An important aspect identified in the caregivers' management of relationships in the workplace was the role of senior staff, especially RNs. Some participants felt that the senior nurse on the shift should fulfil an active role in managing the behaviour of caregivers on a shift, including intervening if any particular caregivers were negatively impacting on the shift team as a whole. The lack of management of these issues was described as a frustrating by participants but this is not an unreasonable expectation as the Nursing Council of New Zealand's (2010) competency framework for RNs requires nurses to provide direction and guidance to other staff such as caregivers.

The second theme describes the importance of having sufficient time to do the work of caregiving and the degree of satisfaction that caregivers gain from their work. This included both the time to perform the physical tasks of caregiving and the time to offer more emotional

support by interacting with and caring about the resident as a person. A systematic review of qualitative research that studied the life experience of residents in ARC facilities explored 31 studies (Bradshaw, Playford, & Riazi., 2012). The aim of the review was to provide recommendations to enhance the life experience of those living in residential care. Using 31 studies selected from six electronic databases they identified four themes – acceptance and adaptation, connectedness with others, a homelike environment, and caring practices. In summary, the authors of this study reported that caregivers are important in enabling this improvement in the lives of residents: "Care staff providing both practical and emotional support can enhance residents' QoL [quality of life]. Organisational policies need to support this by maintaining continuity of care and less rigid time schedules and routines". (Bradshaw, et al, 2012, p. 439) This was supported by the initial exploratory study reported in this chapter as the participants observed that their ability to provide the standard of care they wanted to was influenced by the time available. The care was better care if they felt they were not rushing the tasks and were able to be competent. Not only did the participants say time was important to do a job well; they also described how they knew when this had occurred by what they observed: for example, residents' tidy appearance, clean fingernails and teeth. If the job was not done well, they were acutely aware of this and expressed frustration at not being able to achieve a higher standard of care.

Interestingly, the frustration expressed by the caregivers at not having time to provide the care they wanted seemed to come from a very personal view of the role of caregiver. The participants talked specifically about their passion for caring for older people and the importance of being able to make a difference in their lives, which can be captured by the concept of "compassion". This notion of compassion in healthcare delivery was explored by Travis (2007) in a US study of 221 service workers using the comparable concept of altruism. Using survey methods to explore a model of intrinsic motivation, Travis (2007) noted that while altruism was an important motivational factor for many human service workers in their study, they found that these workers also needed to be supported by management policies and job design. This is similar for the caregivers in the initial exploratory study, where they specifically described an altruistic element in their work. However, this was influenced by having time to do their work, which often required management support and planning their work, that is, the number of tasks required to be completed in the time allowed for a shift.

The relationship between engagement and quality work performance has also been reported in other studies. A study by Callicutt et al. (2011) explored whether increasing workplace

engagement would also increase the levels of professional certification (a process that defines a speciality scope of practice) rates for 82 RNs in the cardiac division of a medical centre in Winston-Salem, North Carolina, US, which in turn would improve positive outcomes for patients. The aim of the study was to implement six strategies that would improve workplace engagement. Included in the strategies were two relevant to the research in this thesis: "Communicating a shared vision" and "Creating a sense of team". The study by Callicutt et al. (2011) reported that the certification rate of the nurses improved from 13% before the study to 37% one year after the study. Based on the premise that nurses who achieve certification contribute to improved nursing outcomes, the study concluded that implementing strategies in all six areas enabled improved engagement in the process, increased certification, and consequently had a positive influence on nursing care, albeit for a specific nursing workforce in the US health care context. No studies considered similar hypotheses in the New Zealand context. The scarcity of research relevant to the ARC caregiver workforce was supported by Kiata et al. (2005) who noted, in the discussion of their survey of 845 ARC facilities, that only few studies have published data on the characteristics of the caregiver workforces in ARC facilities in New Zealand. Their observation suggests that the current study would add to the limited knowledge we have of a New Zealand perspective on these important workforce issues.

The third theme in this study describes the importance of professional development for caregivers, including both training opportunities and performance appraisals. This is consistent with results from another New Zealand study involving caregivers in an Auckland ARC facility. Smith et al. (2005) reported that training was desirable for this workforce to help them to deliver quality care and to feel valued. In this study observational data was collected from 15 caregivers and 39 residents, before and after an education programme was implemented. The authors found a quantifiable increase in the amount of "appropriate and adequate" care delivered after the intervention and a corresponding decrease in the amount of "inappropriate and inadequate" care given. The study limitations noted by the authors included the small sample size and the lack of a control group, but the results support the notion that there might be a link between education and self-worth, which in turn encourages engagement. "For health care assistants the recognition by other staff and management, that they are doing a valuable job well and that they are valued as staff and individual, are considered recognition of their worth" (Smith et al. 2005, p.9).

While the participants in this study agreed that training is an important aspect of enabling engagement in the workplace, they also described the barriers to training that made access to any training opportunities difficult. Because rostering is complex and there is limited funding for education in the aged care sector, it is not surprising that training does not occur in an optimal way. The barriers to accessing training and development opportunities as described by the participants also suggested a reluctance to access any training that was available. However, a recent pay increase implemented in 2017 for all ARC caregivers in New Zealand has been tied to level of qualification, so there is now a financial incentive to access training – albeit often in caregivers' own time. This may mean that fewer people in this workforce would be sceptical about the benefits of attending professional development opportunities. The importance of providing accessible training to improve the competence of this workforce is supported by the wider New Zealand health sector as outlined in the background chapter to this thesis. The action plan from Careerforce has a 20 year strategy that outlines how training and career development for the kaiāwhina workforce will be delivered (Careerforce New Zealand, 2018).

Performance appraisals were described by participants as a useful mechanism for encouraging better workplace engagement. Relevant data is not publicly available in sufficient detail. This can be a complex process; however, a cursory review of the Ministry of Health's current external audit findings of ARC facilities in Wairarapa (as this area is the focus for thesis) shows that only 2/14 (14%) of facilities had "partially achieved" the standard for completion of staff appraisals with the other 12/14 not achieving this standard (MOH 2018). The initial study in this thesis indicated that more regular performance appraisals, done in a timely way, are required if facilities want to positively influence their workplace. However, maintaining a regular schedule of staff appraisals may be difficult with a large number of mostly part-time staff and RNs, who often complete the appraisals, with already full workloads and limited experience in conducting an appraisal process. The experience of the caregivers in this study seems to reflect the reality of the sector.

Limitations of the study described in this chapter need to be taken into account when considering these findings. These limitations include the small sample size, the narrow representativeness of the sample in relation to the wider caregiving workforce (e.g., rural not urban), and the possible impact of the data collection methods (one single interview and three small focus groups) on the study findings. The facilities that contributed to this study were all based in rural New Zealand and may not be typical of larger urban settings. The participant

selection was through facility managers and selection bias could have led to a more limited range of information than might have occurred with a random selection of participants. The participants who did choose to participate were predominantly older New Zealand European women with only some younger workers in the sample. While typical of the workforce the study demographic could also have influenced the types of response to the study questions. The workforce demographic profile of the ARC sector suggests a range of ethnicities in this workforce, for example, Pacific or Filipino, but the sample strategy used in this study did not attempt to completely reflect this ethnic diversity.

The sample size of both number of ARC facilities contributing to the study ($N = 4$) and the number of caregivers who participated ($N = 9$) is small. Nonetheless, the participants in this study provided rich data, which enabled meaningful analysis. The initial study design planned also to use the Q12 to obtain some quantitative data on the participants' experience of their work environment. The questions from this tool were relevant to the research (e.g., "I know what is expected of me at work" and "At work, I have the opportunity to do what I do best every day"). However, the group-based approach to data collection prevented collection of individual level data. This could have been addressed by getting each participant to complete the Gallup tool independently on-line before the focus group meetings. However, such an approach would not have produced generalisable data (the sample size was too small) and may have been a more intimidating way of introducing participants to the study, making them feel evaluated rather than contributors to this research. As such, the Q12 questions were used to introduce the concept of engagement to the focus group, and to facilitate wider participant-led discussion on the study topic. The data analysed in the study came from the verbatim transcripts of the audio-recorded focus groups, although as noted the verbatim data were not easily attributed.

In conclusion, although there are limitations in this study in terms of the sample size, selection of participants, and design, the findings are consistent with findings in the literature that examines the importance of engagement in the workplace, e.g., (Bakker, Arnold , & Demerouti., . 2008, Simpson 2009., Harter et al. 2003.,and Warshawsky et al., 2012). The study helps with understanding how workplace engagement can be encouraged for caregivers in ARC, although their experience of effective teamwork on a shift, leadership support for teamwork, and making time available to not only complete the tasks required but also provide individualised care to the residents. Little research has been undertaken into ARC caregivers in New Zealand to develop understanding of what enables workplace engagement for this

workforce. As discussed, this will become increasingly important as the demand grows for this workforce to provide a high level of skilled care to increasingly frail elderly residents. The findings from this study were used to inform the development of the subsequent research for this thesis. The key themes were incorporated in the methodology design of the next part of the research: a participatory action research (PAR) process described in Chapter Four.

# Chapter Four: Methodology of Participatory Action Research

## 4.1 Introduction

The second study in this research was a participatory action research (PAR) study that expanded on the findings from the first exploratory study and explored in more detail aspects that encourage caregivers to be motivated and engaged in their work in ARC facilities. As discussed in Chapter Two little research has been published that helps understand the workplace experience of this specific workforce: and yet, the increasing number of frail elderly people in residential care will require ARC caregivers to be a capable and motivated workforce.

The approach to the research design was informed by constructivism – a theory about learning and knowledge. Underpinning this research is the belief that the ARC caregiver workforce can be empowered to develop strategies to inform their own professional practice. Constructivism was originally developed as a theory of learning by Piaget in the 1960s and used in education research. Fosnot (2013) also has relevance to research in the healthcare sector, and specifically to this thesis. Constructivism provides a philosophical basis for the use of PAR methodology in this research and implies that knowledge is not simply a collection of objective truths but, rather, that it is constructed through the meaning learners attribute to their observations and experiences in the world. Furthermore, this meaning is developed through ideas that are expressed in language shared between people. Fosnot (2013) thus described constructivism as the theory of gaining meaningful knowledge through discussion and debate in communities of practice.

The research used a PAR methodology to explore the ARC caregiver community of practice by enabling discussion and debate of this knowledge though the use of authentic participation. In this way the participants developed knowledge about their workplace environment through shared meaning. The research design, which included meetings and interviews, encouraged participants to develop this meaning. The qualitative descriptive analysis of ARC caregivers' experiences in Chapter Three identified three key factors relevant to engagement of caregivers in their workplace: (1) good teamwork practices, (2) finding sufficient time to deliver care to residents, and (3) having opportunities for professional development and feedback on work performance. These themes were similar to factors identified internationally in studies of nursing workforces (Bradshaw et al., 2012; Chenoweth, Jeon, Merlyn, and Brodaty.,2010; Vikstrom et al., 2015). By further exploring these themes the research in this thesis aimed to

contribute to knowledge about how to motivate caregivers to consistently provide quality care for frail elderly people in New Zealand ARC services. The methodology chosen for this further study and the study design are described in this chapter, with the results of the study reported in Chapter Five.

## 4.2 Overview of participatory action research methods

Action research is an overarching term for research activities that are designed to result in progressive change rather than simply to produce 'findings' that can be reported in scientific publications. These changes can occur at many levels for individuals, organisations, and institutions, or even at the level of wider society (McTaggart., 1991). PAR methodology is one type of action research and is based on a process originally developed by Kurt Lewin as a methodology to bring about such social change (Lewin., 1946). Within the context of attempting to solve the social problems in post-World War II society, Lewin proposed including people in decision making as problems were explored, thereby enabling a commitment to any identified solutions. The methodology Lewin proposed included four main steps: (1) Planning, (2) Action, (3) Observing and (4) Reflection. These four steps are used in a cyclical process and the cycle can be repeated several times to ensure that the issues related to particular research have been fully explored. This process was developed from the premise that a researcher cannot anticipate all events that might occur in the research process, so to allow for this the process is continually reflected on and refined to ensure that all emerging issues can be accommodated as the research progresses. It is through the repetition of this cycle, at the core of the methodology, that the findings can be continually refined to ensure they have meaning and relevance to the problems being researched and to the research subjects. In a narrative review exploring both historical and contemporary definitions of action research, Dickens and Watson have emphasised that the collaborative and developmental aspects of PAR are essential to the design of this research methodology (Dickens & Watkins, 1999). They used case studies to explore the relevance of the research methodology after over 50 years of development. Their conclusion was that some of the more recent derivatives of Lewin's original methodological approach, for example, PAR, collaborative inquiry, and developmental action inquiry, have "a thread that connects them back to Lewin" (Dickens & Watkins, 1999, p. 139) as evidenced by their review of the selected case studies.

In PAR methodology, an action research approach is used but there is the added element of participation by the participants in the research, not simply the inclusion of them. This concept of authentic participation is identified as underpinning nine core principles of PAR

methodology (McTaggart, 1991). These principles can be summarised as: (1) working collaboratively, (2) understanding the distribution of power in the research process, (3) recognising that change occurs in work groups, institutions, and wider society, (4) the importance of the role of action and reflection in the research process, (5) unifying both theory and practice, (6) producing knowledge, (7) recognising the political context of action research, (8) acknowledging breadth of potential sources of data, and (9) creating a theory of work.

Crucial to using this methodological approach is an understanding of what is meant by participation. McTaggart (1991) outlines the potential confusion between participation and involvement. He claims that: "Authentic participation in research means sharing the way research is conceptualised, practiced and brought to bear on the life-world" (McTaggart, 1991, p. 1710). This does not merely involve participants but ensures they have an active role in the entire research process. This active role in the research is evidenced through the data collected. The type of data collected can be in the form of transcripts of verbatim interviews or meetings, participant observation, field notes, logs, and document examination. The data collected illustrates that participants in PAR are not just learning but are involved in knowledge production and the action aspects of the study. Knowledge production is another of the nine key principles of PAR (McTaggart, 1991). The PAR process enables participants to be curious about their environment and to understand the relationship between the actions and circumstances that exist in their environment. In this way they produce knowledge about the issue being researched.

Another key element in this methodological approach is the explicit acknowledgment of the existence of power and empowerment, for both the participants and the researcher. Specifically, PAR methodology focuses on empowerment and participation of the people and communities involved in a study. This research method enables the researcher to gain an understanding of the experiences of groups of people who might otherwise have little opportunity to be heard or understood. While PAR seeks to assist in developing an understanding of the problems of a group (frequently a disadvantaged community) to achieve empowerment of that group, it also requires an acknowledgement of the power inherent in the relationship between the researcher and the participants. This often necessitates triangulation of the data for validity through discussion with supervisors or other experts. In the research for this thesis, meetings with supervisors and managers in the ARC facility as well as reference to the experience and knowledge of ARC that the researcher (JP) had were used to moderate the influence of these power issues.

The PAR methodology often starts with small exploratory cycles through which the issue of interest is explored, as described by Dickens and Watkins (1999). This is then expanded to include wider groups of participants to expand the potential for solution or actions. The research for this thesis began with an initial study within ARC facilities to explore the motivation and workplace experiences of caregivers. The more detailed PAR design was then developed from this first cycle of plan, act, observe and reflect. This research has the potential to continue to be expanded in this cyclical way into the wider ARC sector; as discussed in Chapter Six.

Public health is defined as "the art and science of preventing disease, prolonging life and promoting health through the organized efforts of society" (Acheson, World Health Organization, 1988). Using this definition, the research in this thesis, which explores ways to promote the health of older people in ARC, could be regarded as a public health activity. Baum, MacDougall, and Smith (2006) propose that PAR as a research methodology is of particular relevance to public health. They claim that while the PAR methodology can be unpredictable and time-consuming, the fact that it is strongly guided by the research participants means it can be legitimately used in a health context to help develop greater understanding of issues in specific communities of interest, for example, mental health communities, indigenous communities, and where it could be used to bring about positive change. "PAR differs from most other approaches to public health research because it is based on reflection, data collection, and action that aims to improve health and reduce inequities through involving people, who, in turn, take action to improve their own health" (Baum et al. 2006 p. 854).

The research for this thesis aimed to improve understanding of how ARC caregivers can be better engaged in their work tasks. Caregivers have already been described as a workforce that is seldom well educated or well-paid and consequently they often do not have a voice to influence their workplace. The use of PAR methodology to achieve the research aim seemed to be good fit not only in that it provided a voice for this somewhat disadvantaged group, but also because it enabled them to identify what encourages their engagement in work. This methodological approach can also help create an environment for sustainable change in the wider ARC sector.

## 4.3 Literature review: Past applications of participatory action research and ARC

To help determine whether PAR would be appropriate for collecting data in this study a focused literature search identified action research methodologies that had been used in

healthcare settings in the past. This was additional to the wider literature review in Chapter Two. This search was conducted in MEDLINE® and was limited to material published in English and since 2000. The search combined the specific term "participatory action research" with the more general conceptual terms of "Nursing homes" and "Homes for the aged". Articles were identified for relevance by screening titles and abstracts, and relevant articles were reviewed and critically evaluated for their potential to give more depth of understanding of the use of this methodological approach. The next sections in this chapter give a summary of the selected literature, followed by some of the relevant findings.

### 4.3.1 Summary of identified literature on action research

The papers identified are summarised in Table 4.1

Table 4.1**:** Selected literature on PAR studies in health care

| **Author, year and country of origin** | **Title** | **Subject** | **Main findings** | **Relevance to this thesis (highly relevant; relevant; indirectly relevant)** |
|---|---|---|---|---|
| Baum et al. (2006) Australia | Participatory action research. | Clarification of key concepts and issues for action research. | This methodology is increasingly used in public health research and for work where it is important to have participation with communities to improve understanding of their issues and create opportunities for change. | Highly relevant – Provided an overview of the validity of using PAR in the wider public health context, e.g. its use in researching indigenous communities in Australia. |
| Froggatt and Hockley (2011) UK | Action research in palliative care: defining an evaluation methodology. | To explore how evaluation methods are integral to a PAR methodological approach in two studies in UK nursing homes. | These examples of evaluation within action research illustrate how diverse methods can be used. Using a specific participatory evaluation model ensures the process reflects the principle of action research. | Indirectly relevant – Highlighted the relevance of evaluation in the design of PAR studies, albeit for palliative care. |

| | | | | |
|---|---|---|---|---|
| Jacobs (2010) The Netherlands | Conflicting demands and the power of defensive routines in participatory action research. | Using PAR methodology in a study to develop intervention programmes to improve the health of older people in a community in The Netherlands. | The research highlighted two major challenges for PAR research – "The hidden meanings of participation" and "recognizing and overcoming defensive routines" (p. 382). | Highly relevant – Developed understanding of some of the challenges in using PAR methodology. |
| Lindeman et al. (2003) Australia | Changing practice in residential aged care using participatory methods | The use of PAR in ARC as phase 1 of "The Well for Life" project exploring nutrition and physical activity. | PAR encourages staff involvement in identifying issues and actions and can encourage change in how resident care is delivered. | Highly relevant – Specifically supported the use of PAR methodology in identifying issues and actions of relevance to care delivery in ARC. |
| Snoeren, Niessen, Abma (2012) The Netherlands | Engagement enacted: Essentials of initiating an action research project. | The role of the researcher in a study using action research to explore how to develop a challenging workplace and improve quality of care in a care facility for older people. | Demonstrated the importance of investing in relationships at an earliest stage in the research to ensure participation and commitment/engagement. | Highly relevant – Highlighted some of the pitfalls in using action research methods for a novice researcher in a residential care setting. |

### 4.3.2 Synthesis of findings from selected literature

This discussion of relevant literature is not intended to be a comprehensive review of literature about PAR: rather, it aims to show how this methodology is of relevance to the health sector and consequently to the design of the research for this thesis. Five studies were identified that illustrated the relevance of using PAR in a health setting, the importance of participation in the design, and the challenges associated with deciding the scope of the researcher's role when undertaking this kind of research.

Baum et al. (2006) in their narrative paper provide an overview of key concepts of PAR in public health contexts. They claim that PAR methodology is increasingly being used in public health settings to explore issues in the planning and evaluation of health services for disadvantaged groups. It could be inferred that the workforce that is the focus of this thesis does not have the advantages of many other health workforces and as a disadvantaged group the use of PAR methodology is appropriate. The methodology would enable caregivers to be engaged and enable their voice to be heard in identifying problems, prioritising, and finding solutions to the question central to this thesis.

Not only does this paper by Baum et al., (2006) support that this methodology is appropriate for this workforce, it also highlights some challenges in the use of PAR that are important to note. For example, they indicate that while PAR is useful in gaining participation of the end-user of research in the design and implementation of that research, this approach is dynamic in that it can have delays that extend timeframes, and the evolution of the process can be unpredictable. They discuss key concepts of power and empowerment in PAR, particularly the power dynamics that occur within the researcher and participant relationship. They indicate that the PAR process involves a subjective partnership approach rather than the more traditionally objective approach taken by other research methodologies. To address these aspects they note that PAR uses reflection in the cycle of research to ensure the balance of power between the researcher and the participants is constantly acknowledged as part of the process.

Snoeren et al. (2012) addressed this concept of power in relationships in a study conducted in the Netherlands. This paper study aimed to illustrate the tensions that occur in a PAR process when the values of the researcher can come into conflict with those of others in the research study. Effective relationships underpin the authentic participation essential to PAR methodology and this study proposed that recognising elements such as values conflict in the relationship between the researcher and participants would enable the researcher to reflect more deeply on their process and consequently add to the learning from the research. Using

an ethnographic approach they describe a study undertaken in a care facility for older people. The facility (called a Care Innovation Unit) was a collaboration between three organisations: two schools of nursing and a care facility. The purpose was to create a workplace environment that would use principles of practice improvement in the delivery of care. The primary researcher (a lecturer in one of the nursing schools) joined the clinical team in a new ward as a consultant to facilitate the change process using an action research process to build the knowledge and skills required. Over a period of more than 12 months the researcher worked with participants, led by the nurse manager, to help them facilitate the development of a constructive workplace and high quality care. Early in the research problems were identified in the relationship built between the researcher and the nurse manager as they worked to establish their roles and the processes to be used.

Relationships are fundamental to the design of PAR and the impact of a poor relationship on the action research process was described by Snoeren et al. (2012), where the researcher and the nurse manager had conflicting values and beliefs about the roles and process of the research. For example, they described a situation where the researcher, who valued inclusion, wanted all staff to attend meetings while the nurse manager, who favoured exclusion, wanted only those on the permanent nursing team to attend. The descriptive data suggested that the researcher and the nurse manager were engaged in a values clash. This conflict in their relationship hindered the research process and caused significant frustration for both the researcher and the participants as well a loss of momentum in the research and potentially the non-achievement of the outcome, which focused on improvements in care delivery.

The study by Snoeren et al. (2012) provided insights for novice researchers into the importance of creating effective relationships using PAR methodology. As well as identifying the potential barriers to building effective relationships in the action research process they stated that mindfulness and self-reflection are tools that can assist in managing this complex but essential element of the action research process.

Other challenges in the use of PAR methodology are discussed in a study by Jacobs (2010). This study had a health promotion focus and was conducted over two years in an older person's community in The Netherlands. It examined the issues in authentic participation as required in PAR and the impact time constraints can have on this being done in an inclusive way. The aim of the research was to gain insights into what constituted healthy living for older Dutch and Moroccan people in lower socio-economic areas in The Netherlands. These insights were intended to enable the promotion of strategies to encourage health and well-being in this community using a cooperative approach. The author of this study proposed to

develop ways to promote health outcomes in the community by giving members of it more control over their life and health choices. Data collection included both prospective data, for example, minutes of meetings and emails about how the project was to be implemented and retrospective data, for example, interviews and focus groups. From these data (Jacobs, 2010) identified a tension between community participation and ensuring the quality of the research, as the researcher's and the participants' views about what participation meant differed. For example, when the first interview data were analysed after 18 months it was clear that the time targets for a practical outcome might not be achieved. This put pressure on the researcher to manage the time needed to attend to the relationship in the research as required in PAR and meet the outcomes. Jacobs (2010) proposed that the resolution of this type of tension can be helped by developing a shared understanding with the community of interest and the researcher of what participation means. Jacobs (2010) indicated that having an external coach, someone not involved with the research project, could assist in recognising the issues that could undermine authentic participation in the project. The solution in this study was to ensure open discussion and reflexivity in the research process and ensure that the multiple perspectives that are inevitable in PAR were managed.

Understanding this tension was relevant to the research in the current study as it created awareness that flexibility was needed about the time required to arrange regular meetings with thesis supervisors and ARC facility management and to ensure there was ample opportunity to reflect on whether full participation was occurring. Even with this knowledge lengthy delay sometimes resulted, which slowed the momentum of the research and required active facilitation by JP to ensure the momentum was not lost. This experience highlighted that PAR does not occur in a linear or predictable way.

PAR has also been used in evaluations of other types of health services, as demonstrated in a study by Froggatt and Hockley (2011) who explored the use of PAR in a palliative care setting. The data for this study was collected from two case studies: the first was in developing a palliative care approach over five years in two nursing homes in the UK and the second was a peer education programme in Sweden for advanced care planning for older adults delivered by five peer educators. The study by Froggatt and Hockley (2011) used a PAR process to evaluate the programmes and concluded that PAR was an effective way to evaluate health services. They used observation, questionnaires, and interviews to collect data on how well the programme had worked and compared five features in an evaluation process: (1) judging the value of something, (2) gathering valid information, (3) using a systematic way of working, (4) making a comparison and (5) making a more informed decision, using

the PAR process. The two studies were considered against these features and each demonstrated elements of all five features. Froggatt and Hockley (2011) argued that these studies showed the value of integrating evaluation within a PAR framework and for informing the design of PAR research activities and enhancing the outcome of the research. While the work by Froggatt and Hockey et al (2011) did not specifically focus on ARC, the features they describe were relevant to the design of the research for this thesis: specifically "Step Three – Observe" and "Step Four – Reflect". These steps, which mirror Lewin's evaluation process, formed the basis of the research process.

Lindeman et al. (2003) highlighted the relevance and utility of PAR methodology specifically in ARC research. The "Well for Life" project was undertaken in Australia by the National Ageing Research Institute with the aim of enhancing quality of life for people in ARC by empowering staff to make changes to their practice. This paper reported on the process and outcomes of the action research in Phase I of this large project, which was undertaken in the late 1990s and included five ARC facilities. Lindeman et al. (2003) reported on a case study in a 44 bed facility, with residents who required low levels of care, which focused on the role of menu development in support of good nutrition. They held a series of meetings with staff to brainstorm how they could better understand the food preferences of residents, how the menu could be varied, and meal presentation could be improved, while not losing nutritional value. They developed ideas and identified barriers to implementation. Feedback from staff indicated that the process had been worthwhile. The study gave some key aspects that assisted this process for example, having a clear start-up process, choosing an effective facilitator, including all staff, and providing education sessions. In their conclusion about the use of a PAR process they indicated that their main finding supported encouraging staff to identify ideas and actions as a means to improve clinical practice. While this research is now somewhat dated and specific to nutrition and ARC services in Australia, rather than New Zealand, it demonstrates that this methodology is a robust and useful way to explore issues for the care delivered by caregivers in ARC.

## 4.4 PAR Methods used in this study

This section outlines the PAR methodology used in the current study. It gives an overview of the study method, the design of the study, how participants were recruited and included in the process, and how data were collected and analysed. The detailed research journey is reported in Chapter Five. The study was approved by the Human Ethics Committee of the University of Otago (Reference number H16/087) (Appendix 4). This approval document included the research protocol, communication documents, and consent forms, which were used to recruit

the facility and the participants within it. Presentation of methods for a PAR study can be challenging because, unlike more positivist methods, decisions about what to do in each stage of the research (e.g., who to recruit and what data to collect) changes as a direct result of the research process. As such, some of the methods presented below necessarily include information about aspects of the research that might be considered "results" in more mainstream quantitative or qualitative research.

### 4.4.1 Study design

The initial study described in Chapter Three used an exploratory approach to highlight the issues for caregivers in ARC. From the results of this study a second PAR study was designed. The second study, which is the focus of this chapter, followed the four steps of Lewin's model in a more formal way resulting in a four step design: Step One – Plan, Step Two – Act, Step Three – Observe, and Step Four – Reflect. While PAR requires that the research design is done with the authentic participation of the participants recruited throughout the process, an initial protocol for this research was prepared by JP and her supervisors. The intention was to give an outline of the process so that ethics approval could be obtained and to give some indication of the project to assist in the recruitment of both an ARC facility and participants. However, the initial protocol indicated that there was scope for, and expectation of, the participants to be involved and to refine and influence the final methods used in the study.

#### *4.4.1.1 Introduction to the process*

The study participants were the ARC facility manager and staff, mostly caregivers, in a facility in rural Wairarapa, New Zealand. The facility was chosen primarily based on the ability and willingness of the manager to support the research process. Only one facility was chosen for this research, as qualitative research is often based on rich data gathered from small samples, with a focus on explanatory understanding rather than on statistical generalisability, as described by Ritchie et al. (2013). Written informed consent was obtained at each step as new participants were recruited. A detailed description of the facility and the staff are included in section 5.2.1.

The facility manager's support was essential in the process as the research design required staff to have time away from their tasks and rosters that enabled them to attend meetings and interviews. The importance of early engagement in the research design by key participants is highlighted by Snoeren et al. (2012). They advised that gaining engagement and having openness to the ideas of others is essential to ensure full participation. In this research a letter

of support from the Ethics Committee of the facility was obtained to formalise this process (Appendix 3). This also gave a formal record of engagement between JP and the facility. The support of the management and governance of the facility was essential to ensure that any difficulties along the way were managed and worked through in a positive way with the staff, manager, and JP. As described above, PAR methodology requires authentic participation from research participants in its design and implementation. The research design requires a degree of flexibility and, rather than pre-specifying all aspect of a study as is usually required in more positivist approach to research, the researcher needs to be able to adapt methods as the study progresses. A key example of this was where the original time-frames proposed for the study were delayed to accommodate the recruitment of a new nurse manager for the facility. Although unanticipated, this had a positive effect on the research as the new staff member was very interested and committed to the research process, and as a new employee was likely to be present for the entire process.

#### *4.4.1.2 Step One: Plan*

The objective of Step One was to ground the project in a rigorous process that would ensure the data collected was meaningful. Essential to Step One was the establishment of an advisory group of caregivers to enable the participants to drive the development of the action plan and provide continuity of participants throughout the study. The people in the advisory group were recruited as participants in the study, using purposive sampling and assistance from the manager. The recruitment started when JP gave a presentation to a general staff meeting to ask for volunteers to join the advisory group.

The advisory group met regularly throughout the project to ensure that the research process and data collection accurately reflected the experience of the caregivers. The outcome of the four group meetings was a nine point action plan (Table 5.4) which the participants presented to two of the facility managers. The action plan developed by the group was based on strategies that could assist in understanding how they build teamwork, resident-centred care, and professional development – the three themes independently identified in the study described in Chapter Three.

In Step One some relevant audits were identified, as it was proposed the data they collected could provide a useful outcome measure for this research. These audits included staff satisfaction surveys and incident/accident reports.

#### *4.4.1.3 Step Two: Act*

The objective of this step was to implement the action plan agreed to by the advisory group and management in the final meeting in Step One. The priority action from the plan was the implementation of regular caregiver-only meetings with the nurse manager. This was regarded by the advisory group as the most critical action in building teamwork, identifying strategies to enable more time with residents and addressing professional development opportunities. The facility management accepted the action and agreed to implement it as part of their "business as usual" practice. Participants in Stage Two of the study included those already recruited in the advisory group, plus additional caregivers from the residential care facility who were invited to attend the caregiver-only meetings. All the meetings in the facility were open to all relevant staff, so this was presented as another opportunity within the facility for any caregiver staff to attend. The functioning of the caregiver-only meetings required the commitment of the nurse manager, who arranged for notices about the meetings to be put in the staff room, allowed payment for the time staff attended, and encouraged all caregivers to attend. JP attended as an observer for the first four meetings. These were hour-long meetings and were held each month between February and May 2017. The other actions noted in the action plan were planned to be implemented over time and as resources allowed. The nurse manager gave a verbal commitment to continue the implementation of these additional actions in future.

#### *4.4.1.4 Step Three: Observe*

Step Three evaluated the effectiveness of the action plan designed in Step One and implemented in Step Two. This part of the research design included interviews with individual participants about: (1) their experiences and views on the actions taken in Step Two; (2) their impressions of the impact of actions taken in Step Two in terms of worker engagement and quality of resident care; and (3) their overall experience of the PAR process. The six interviews were conducted (1) the advisory group ($n$ = 4); (2) a purposive sample of other caregivers based on availability and willingness to participate ($n$ = 2); (3) the facility manager; (4) registered/enrolled nurses ($n$ = 2); (5) the quality manager; and (6) the nurse manager. Additional consents were needed at Step Three as this part of the PAR process included semi-structured interviews with staff who were not part of the advisory group. These consents were obtained from the quality manager, one registered nurse, one enrolled nurse, and two additional caregivers. The interviews were conducted face-to-face in the facility for up to 60 minutes and were audio recorded and later transcribed. The interviews were semi-structured, based on a pre-specified set of questions (Appendix 7) and often needed some

flexible questioning that suited the particular responses from individual participants when more information was required. The questions were not pilot tested before use as they remained flexible so follow-up question could be used to clarify the responses if necessary. For example, the quality manager talked about her initial resistance to the implementation of a caregiver-only meeting and indicated that she had changed her mind about this as a result of the PAR process. Understanding this change required more in-depth exploration.

#### *4.4.1.5 Step Four: Reflect*

The aim of this step was to reflect on the entire PAR process and on the results from the analysis of the data collected in Steps One to Three. The initial analyses of findings were presented by JP to facility staff, who were invited through an open invitation to all staff who wanted to attend the meeting. The purpose of the meeting was to provide an opportunity for feedback on the findings, to invite staff feedback on the relevance of the research results to the original research aim, and to explore any implications for the wider ARC sector and further research. No additional data collection or additional consents were required for this step as most participants had already consented and the couple of additional staff who voluntarily attended gave verbal consent in the meeting The meeting was not recorded (as not all attendees had given written consent) but the key outcomes were recorded as field notes by JP and validated after the session with the managers who attended the meeting. The participants were a cross-section, by age and role, of all staff in the facility, and actively gave their views on the process and suggested improvements for future research.

### 4.4.2 Details of participant recruitment

The first phase of recruitment was a verbal request to meet the manager of a residential care facility in Wairarapa, to ascertain the possibility of conducting the research in this facility. The subsequent meeting resulted in a commitment to support the research project being undertaken in this facility. The facility, Carter Court, is a 42 bed ARC facility providing a mix of hospital level care and rest home level care and one respite care bed. These distinctions in levels of care are detailed in Chapter One.

### 4.4.3 Data collection and analysis

#### *4.4.3.1 Step One*

Data collection in Step One involved audio-recording the three meetings facilitated by JP with the caregiver advisory group ($N$ = 4), and the meeting where the advisory group presented the action plan to the facility management. These four meetings were approximately 60 minutes in length and included an introduction, setting of ground rules, clarification of the role of the

advisory group, and encouragement to speak openly. The meetings and interviews were held at the facility, in whatever room was available, without the manager present (except for the meeting where the advisory group presented their action plan). The decision to exclude the manager from these meetings was made to encourage participants to speak openly, which the manager understood and agreed to. The meetings and interviews were held in the early afternoon to enable most staff to attend before or after their shifts. One participant did regular night shift and participated on her day off. The original design included additional meetings with the facility manager and nurse manager to validate the data, but these proved unnecessary as the facility manager and nurse manager provided informal guidance and support to the researcher during the process. Audio-recordings were made of the advisory group meetings to allow review to ensure accurate interpretation of data. As noted above, part of the design of Step One was to identify relevant internal audits. However, these were not used as the data they collected was of a general nature and could not be directly associated with the implementation of the action plan. The final draft of the action plan was also part of the data collection.

#### *4.4.3.2 Step Two*

The researcher attended four of the caregiver-only meetings at Step Two (See Appendix 9 for dates of meetings). These were not audio recorded but field notes were kept by JP. This was appropriate as additional staff were in attendance who had not given consent but wanted to attend this facility meeting and detailed clinical content not relevant to the research question was discussed. Written consent forms were obtained from all these staff and all participants remained with the research process to the conclusion, no one dropped out. Informal validation of these observations was conducted in discussion with the nurse manager (who attended every meeting) and a review of the minutes of the meeting.

#### *4.4.3.3 Step Three*

At Step Three data was collected through interviews and as with Step One, all the interviews were audio recorded and transcribed. The focus of this Step was on understanding how the participants experienced the PAR process – any changes they had noticed as a result of the implementation of actions in the action plan and any comments about future research in the ARC facility. A set of interview questions (Appendix 7) was developed to assist with consistency but there was also opportunity to allow new ideas to emerge and in-depth follow-up of relevant ideas that were raised in the interview process.

#### *4.4.3.4 Step Four*

Step Four, the final phase, involved a meeting to feed back the results. This meeting was not audio recorded as a number of additional staff chose to attend who had not formally consented to this type of data collection. Instead, field notes were collected on general feedback and perceptions from the participants in this Step, rather than their verbatim responses. These data were then validated after the meeting informally through discussion with the nurse manager, who was present at the meeting.

All audio recordings made in Steps One and Three were transcribed verbatim and analysed line by line using qualitative descriptive analysis. NVivo Pro 11 was used to organise and manage the study data. PAR is a qualitative methodological approach, which requires that constant comparative methods are used to analyse the data. This was the process used to code the data to enable the identification of themes and ideas from the meetings. Each transcript was read and coded by JP with subsequent re-reading and coding incorporating findings from additional data, which was discussed with a supervisor (WL). The transcripts were not returned to participants for comment, but their feedback was sought once the themes had been analysed and an overall model of the data could be presented to them. A matrix, which included 16 codes and five categories, rather than a code tree, was used in the analysis process to enable themes to be compared. This matrix was used to identify the relationships between identified codes and categories. In addition, the researcher discussed and shared the written data, transcripts, and coding with research supervisors. This ensured the rigour of the analysis, and that the ideas did indeed emerge from the data rather than being imposed on them. The researcher kept field notes from observing process in the caregiver-only meetings and of the PAR research in general. These were also analysed and are reported in the results section.

Throughout the research process JP kept personal field notes of observations and impressions of the process and the responses of participants. These notes were added to the data set and analysed using NVivo for themes and ideas alongside the interview data, contributing to the overall study findings. This provided an opportunity to triangulate the results from the transcripts. As in the initial study, the themes and ideas were also tested for relevance in discussion with the facility manager and nurse manager in informal meetings and considered for trustworthiness by reference to the ARC experience of the researcher. A final validation of the analysis occurred when the model that was developed from the analysis was shared with the participants at Step Four.

## 4.5 Summary

PAR methodology is used in health research to provide an opportunity to engage communities, reflect on the data collected, and assist participants to develop deeper understanding of their world so they can make changes (Baum et al. (2006)). The research design in this thesis focused on the caregiver workforce in ARC and, specifically, the ways they could be encouraged to be engaged in their workplace. In line with PAR the methodology in this study was dynamic in nature and changed as the process unfolded, which in turn required flexibility and responsiveness from JP. At its heart, this methodological approach required a level of trust in the experiences and knowledge of participants so as to be guided by them. The results of research using this methodology are interpreted through the experience of the researcher. For this study it was beneficial for JP to have experience both as a social worker in aged care and former manager of a large ARC facility in New Zealand providing three levels of care – rest home, hospital, and secure dementia care. Having a researcher with experience of the sector encouraged caregiver participation as there was a shared language and a joint understanding of the issues. In addition, having professional health social work experience ensured that JP had the facilitation and interview skills to assist in the data collection. The background and experience of JP enabled credibility to be built and authentic participation at all levels as required in the use of PAR methodology. Chapter Five provides detail on the research journey and the results.

# Chapter Five: Results

## 5.1 Introduction

The previous chapter outlined how the PAR methodology was selected and designed, and the data collected. This chapter reports the results of the data collection and its analysis by describing the overall research journey and its link to the research methodology. The chapter discusses the development of a model derived from the data that describes three factors influencing caregiver engagement in their workplace and how these factors interrelate.

As a PAR study, the results of this research are not entirely reported like other study methods (both quantitative and qualitative), which commonly only focus on the end point of the work. In this study, reporting on the journey taken to reach this end point is equally important, as the experience of the journey (what worked and what did not work) is an integral part of the study "results". As such, the first part of this chapter focuses on data gathered during the four stages of the PAR process (plan, act, observe, reflect). The latter part of this chapter focuses on describing the model that emerged from the data collected through meetings and interviews. This chapter describes how the PAR process worked, as an intervention, to improve understanding of ARC caregiver engagement in their work.

The PAR study was conducted in an ARC facility chosen because the manager was willing to embark on a research process (as part of a JP's PhD course of study) to help identify what would assist in ensuring the caregiver staff could be fully engaged in their work. The facility had implemented a substantial change to their model of care and the manager was interested in using this research process to gain better understanding of caregiver engagement and also to support the rebuilding of staff competence and confidence following the change to the level of care provided to the residents. The PAR work occurred from May 2016, when initial discussions were held with the facility manager, until November 2017 when the model was presented back to the participants for their comment.

## 5.2 The research journey and links to PAR process

### 5.2.1 Step One – Plan (co-designing the actions)

There are 14 ARC facilities in the Wairarapa District Health Board area ranging in size from 20 beds to 78 (Ministry of Health, 2018). The Wairarapa region is a predominantly rural area with a total of 43,890 people. Most of the population live in one urban centre, Masterton (population approximately 25,200), with three smaller towns: Carterton (population

approximately 4,686), Greytown (population approximately 2,199), Featherston (population approximately 2,253), and Martinborough (population approximately 1,470) (Statistics New Zealand, 2013). The rest of the population is widely dispersed in often remote rural areas. As seen in Table 5.1 the Wairarapa District Health Board population is slightly older than the national average with a similar proportion of Māori people, fewer Pacific people and slightly more people in areas of high deprivation compared to the general New Zealand population (Ministry of Health, 2018).

**Table 5.1:** Summarised comparative Wairarapa DHB population statistics

| | **Wairarapa** | **New Zealand** |
|---|---|---|
| Aged 65–90+years | 38.2% | 20.8% |
| Māori | 17.5% | 15.8% |
| Pacific | 2.0% | 6.5% |
| Deprivation Quintile 4 | 27% | 20% |
| Deprivation Quintile 5 | 20% | 20% |

The starting point for this research journey was a meeting between JP (female researcher) and the manager of Carter Court Rest Home, Carterton. The facility was located in a small town and was a registered charity with legal status as an incorporated society. It had a governance structure consisting of an executive committee and various sub-committees, and was managed by the facility management team. The facility and committee have strong community support through active fundraising and volunteers. As well as the single storey residential care building with 42 beds it has 26 self-contained units on site, which are a mix of rental and ownership properties occupied by people who live independently and have no personal care delivered by staff from the facility. In May 2013, prior to this research, the facility had achieved a four year certification (the highest that can be achieved by ARC services in the formal process required by the Ministry of Health). The facility had consistently high occupancy (approximately 98%), which reflected the high regard held by the community for this facility as a provider of quality care for older people. This would suggest a high level of care was already provided, which may be an important consideration in interpreting the outcomes of the PAR process.

The facility had recently made some significant changes to its service delivery. It previously provided 42 beds for older people who were assessed as being at rest home level and had

implemented a service change, in December 2015, when 13 of those beds were redesignated to provide hospital level care. While levels of care are described in detail in Chapter One, in summary: rest home level care is for those people who need assistance with personal care but are often independently mobile and have reasonable cognitive functioning; hospital level care is for those people who have significant mobility issues (e.g., requiring two staff to assist with mobility); and dementia care is for those people who require a secure environment to ensure their safety. Carter Court did not provide secure dementia care.

The transition from rest home to hospital level care is a comprehensive process requiring a formal audit from the Ministry of Health 2013, which was achieved by the facility in a partial provisional audit in 2015. Funding is increased if a facility is accredited to move to a higher level of care but this is off set by the requirement to increase staffing numbers and increase the availability of equipment, for example, hoists or pressure relieving mattresses. The increased availability of equipment is required to meet the needs of frailer residents. For the delivery of hospital level care the ratio of caregivers to residents must increase and an RN must be on duty for 24 hours a day rather than just being on call as in rest home level care, as detailed in the Health and Disability Sector standards (Ministry of Health, 2018). To meet these requirements there often needs to be a significant increase in the staffing numbers and skill level of all staff. As well as these tangible changes when a higher level of care is approved there may be less obvious attitudinal changes required by staff providing care to a frailer and dependant group of residents. In practice, the caregivers need to provide more assistance to residents who can be very demanding as they adjust to a significant loss of functioning. This requires not only the development of skills and knowledge but an attitude and understanding of how to work with residents in a way that ensures they have dignity and respect in their care. This way of working requires effective teamwork and good communication.

The manager at the facility was aware that the changes implemented for service delivery over the previous year had impacted on the performance of the staff. The current staff had experienced a reduction in their hours of work and number of shifts, a new leadership model had been implemented – with an RN rostered as the team leader for every shift – and staff members were now required to learn how to safely use new equipment such as hoists. At the start of the research process the manager described the workforce as being somewhat disengaged as a consequence of these changes and was very enthusiastic about being part of a research process. This process might not only assist in improving the current level of engagement, but also might ensure that staff engagement was sustained by supporting their

competence and confidence. This was highlighted by the facility manager in an evaluation interview.

> "Well we came out of a difficult period where we transitioned into hospital level care, and when we did that, I think we had to cut hours, and work with home assistants [caregivers] around their hours, and things like that, and I really do feel that that undermined morale at the time. And some of that was around our occupancy too, which was low. So we had a whole bunch of things happening there (. . .) I'd always like to think (. . .) we like to talk with staff, and consult with them, but I do think that we have achieved a different level now [after the PAR research was completed] which is you know, different from the past, and I'm seeing that in the staff meetings, as well." [Facility manager, evaluation interview]

At this initial stage there were two issues to manage before the research journey could begin. Firstly, the facility had an ethics committee (a sub-committee of the Board), which required details of the project as well as confirmation of formal ethics approval from Otago University before the research could commence. The existence of this type of sub-committee at governance level is not common in smaller ARC facilities, in the experience of JP, but indicates the level of commitment this facility had to the quality of care of residents and creating a healthy work environment for staff.

The second issue related to the resignation of the nurse manager, the most senior clinical staff member in the facility. This resignation occurred before ethics approval was obtained and delayed the start of the research. The support of management is vital in implementing the PAR process, so it was decided to wait until a new appointment had been made. The importance of management support was confirmed in the data by comments from the facility manager in the evaluation interview.

> "I think the support of management is really important. You know, 'cause there's so much more that home assistants can do if the management are there to really support that, and encourage it. I mean my challenge, you know, as where I'm sitting now is how do we actually get more home assistants on board with this, how do we get them more engaged. (. . .) we've started something, [the research] and I'd like to see that continue." [Facility manager, evaluation interview]

The delay until a replacement person while frustrating at the time, proved to be an important aspect of the research journey. The nurse manager who did become involved in the research

actively supported the communication of the research design to staff and the recruitment of participants, and supported the implementation of the action plan designed by the participants.

The facility employs 50 staff, most of whom are in part-time in roles (Table 5.2).

**Table 5.2:** Staff at the participating ARC facility

| **Staff role** | **Number of staff in this role** |
|---|---|
| Registered Nurses | 8 |
| Caregivers | 20 |
| Cleaners/laundry | 6 |
| Kitchen | 6 |
| Administration/Reception | 2 |
| Recreation programme | 4 |
| Management | 3 |
| Property/Maintenance | 1 |
| Total | 50 |

The facility also has a small number of volunteers who provide additional support for residents, for example, assistance with activities or providing entertainment. The staff are predominantly New Zealand European with two (part-time) staff who identified themselves as Māori and one staff member who identified themselves as Pacific. One resident identified as Māori.

The next phase was to discuss the project with the manager and nurse manager, then present the proposal to the ethics committee, a subcommittee of the Board of Trustees. Once their approval was granted and the University of Otago Ethics Committee approval was obtained the research process commenced. With a new staff member appointed to the nurse manager role the recruitment process started.This process was initiated by a presentation of the research proposal to all staff at a regular staff meeting and an invitation to caregivers to join the advisory group. A poster that gave the opportunity to participate in the research was advertised to all staff (by being placed in the staff room in November 2016) inviting them to attend the staff meeting to hear more about the research and JP. A general staff meeting (9 November 2016) to outline the project to all staff and invite participants to join the advisory group was attended by JP. The process of setting up an advisory group was instrumental in

the research design and data collection and illustrated the full participation of research participants, which is essential in the PAR methodology. The staff in this facility already knew JP from a previous role and were informed about the reasons for proposing this project and invited to ask questions. Despite some anxiety by JP as to whether there would be any interest at all, the process was successful in identifying those caregivers who self-selected to be part of the group. There were fewer participants than originally anticipated, with only four confirmed members. However, this proved to be a positive change to the design as the smaller number enabled more in-depth discussion. The small group size also meant that if not all the group could attend particular meetings they were easily able to communicate amongst themselves to ensure information from meetings was passed on to all participants.

Formal consents were obtained from all participants and the final advisory group of caregivers began and soon became well established. The group consisted of all women, which is consistent with the current demographic profile of ARC caregivers in New Zealand (Ravenswood., 2014). They worked across the range of possible shifts; morning, afternoon, and night. One participant in the advisory group self-identified as Māori, and the other three as NZ European and the work experience in ARC of the advisory group members was between 2 years and 30 years. The establishment of the caregiver advisory group was a key element in the research design and an example of methodological flexibility.

The advisory group met monthly for four months (Table 5.3), with JP attending each meeting to facilitate discussion, to audio-record the discussion, and to take field notes during and immediately after detailing observations of the process. The initial study in this thesis, as described in Chapter Three, identified three themes of caregiver work that could be explored in more detail to understand how the ARC workforce could be enabled to be engaged in their work. These three themes provided an initial foundation for the discussions held in the meetings with the caregiver advisory group. The discussions from these group meetings resulted in an action plan that the caregivers developed (Table 5.3). Each meeting built on the previous one, although at times it was difficult to ensure that all the participants attended and that they kept up with information as it was discussed if they could not be there. This was partly due to the nature of shift work in the facility. The shifts worked by staff were sometimes changed in the roster to meet changing resident needs, meaning they could not attend a planned day-time meeting as they may have worked the night before. On other occasions planned annual leave meant staff were not available. As mentioned in the previous chapter this is indicative of the dynamic nature of PAR methodology and the requirement for the researcher to be flexible and allow the participants to manage much of the process.

However, at least three of the four advisory group members attended each meeting (20% of the total caregiver workforce ($N$ = 20), which gave some consistency (Table 5.3), and each meeting was about an hour in length.

**Table 5.3:** Attendance at advisory group meetings

| **Date (2016)** | **Number of Attendees** |
|---|---|
| 30 November | 3 (1 recruited after first meeting) |
| 7 December | 4 |
| 14 December | 3 |
| 21 December | 4 |

Attendance at these meetings (four hours in total) was a significant time commitment for these staff, some of whom attended on their days off or after nightshift, although all were paid for their attendance. The payment for attendance indicated how supportive the facility manager was of the research process. The work that caregivers do is physical with a lot of interruptions, but they were observed to fully participate in each hour-long discussion, which required them to sit in a meeting room and focus on the discussion. Some of the comments in the first meeting indicated how they quickly developed expectations for how this process would assist them in their workplace.

> "I think a lot of it is the frustration, there's the lack of communication (. . .) and if we can actually improve that, we're actually going to improve working as a team." [Advisory group, meeting one]

Although the process was a more sedentary one than they were used to, the participants were observed by JP in the meetings to maintain their focus, which they demonstrated in their very vocal input. They sometimes talked over each other in their enthusiasm to contribute as they felt so strongly about the workplace issues they were discussing. The extract below illustrated how in the advisory group meetings they identified issues (workload management), disagreed with each other (said no if they had a different idea), offered contributions (how to delegate the tasks for serving residents morning tea, writing notes, and answering call bells for assistance), and offered solutions (to ensure all tasks were achieved).

> "Yeah, like for example this morning (. . .) I was floating [an additional caregiver role on the shift] this morning. I was out doing the morning teas [for residents]. R [caregiver] had come back and J [caregiver] was out having her morning tea. Was

> going to take over so that I could go and have morning tea, and I said ‘well actually, no, I would rather you sit at the desk, do your notes, I can finish the morning tea as soon as J comes back then I can go, ’cause if the bells ring, you’re available to answer the bells.” [Advisory group, meeting one]

They were also observed by JP to follow this up this problem identification and solution finding process with positive remarks that supported each other’s ideas.

> “I think [there is] an issue (. . .) K [caregiver in the advisory group] sort of bought up, the contamination issue. There’s more contamination with the caregivers handling food than it is with the kitchen.” [Advisory group, meeting one]

This was arguably a high level of communication skill within any team, especially for a team of whom some have limited formal educational achievements. This observation and the resulting evidence that this level of communication was occurring in the workplace was important in understanding how this workforce engaged in their work. In discussion with the participants they determined the time and place of each advisory group meeting to fit in with their shifts and days off. They were all keen to be involved and reported using text messaging to remind each other to ensure as many as possible would attend.

The meetings did not take place in a staff room as anticipated in the initial design. Therefore, there was not always a white board for recording notes, and interruptions occurred. The reality of running a PAR process in a workplace required some accommodation of place (often being required to use a vacant resident room) and the need to cope with interruptions both from extraneous noise outside the room and people entering or leaving the room. The original design proposed that JP would write on a white board with the intention that the participants would be able to see the ideas they were producing and this process would also support validation of the data collected through audio recording. However, the transcriptions of the audio recordings became the key data and the collation of ideas was achieved by developing and sharing an action plan, both draft and final versions, with the group. The validation of data was achieved by verbally summarising each meeting at the end of the session and asking for comment. Also, the action plan was presented to the advisory group members for comment before it was presented to management. Although JP guided the participants with questions that kept them focused they were actively involved in determining the content of the meetings, as illustrated in the extract below where a participant returned to a previous topic as she had more to add.

> "And going back to the rotating the rosters, it says it provides opportunity for staff to experience each shift. So, that would actually [help] in managing time too. But in saying that, I mean if you're doing the other shifts, it actually gives you that little bit more clout, to actually understand what they're doing, what you're doing, and you know, it's actually giving you more sort of control, because you can say 'well hey, you know, I've been doing this shift.'" [Advisory group meeting three]

#### *5.2.1.1 Meeting one*

The first advisory group meeting established the meeting process, which included agreeing on ground rules for team behaviour at the meetings. This was important to ensure that everyone had a shared expectation of the meeting process, especially regarding issues such as confidentiality and the importance of allowing everyone an opportunity to speak. The group discussed how they would manage any issues of ethical or health and safety nature that were raised. The outcome was that they agreed that if any issues of this nature arose they would be discussed with the group and a plan for made for how to raise them with the facility manager. The management of any health and safety issues that were raised was a requirement of the facility Ethics Committee and had been discussed with the facility manager prior to starting the recruitment. All participants agreed with this, but no issues arose out of the research that required this resolution process. At times, the participants needed to be guided to stay with the focus of the meeting. Once they became comfortable with the meeting process they tended to move the focus on to issues relevant to the care of specific residents rather than actions to develop team work and job satisfaction. The caregivers appeared to be most used to their workplace discussions being task focused, with limited opportunities prior to this research opportunity to consider more challenging strategic or wider workforce issues. As such, getting the participants to look at their work from this wider perspective took a little time and perseverance as demonstrated in the comments below.

> P: "You do, you have to rely on whoever your offsider is, you've got to rely them, and you've got to have faith in that person, cause otherwise you might as well just kiss them goodbye."
>
> JP: "Do you think everybody understands what teamwork is?"
>
> P: "No."
>
> P: "No I don't think they do, so that would be another good thing."
>
> JP: "So what would you— what do you think you could about that, to help people understand what teams are?"

P: “I think it’s ‘I know better’, and that sort of talk, ‘don’t need you telling me how to do my job.’ Doesn’t matter if I’ve been here two years, I know everything in here because it’s me, I know everything.’ Well I’m sorry, but I’ve been in this job three years, and there’s always something new that you can learn.” [Advisory group, meeting one]

#### *5.2.1.2 Meeting two*

The second advisory group meeting built on the first by revisiting topics that had arisen in the initial study and in the previous meeting. In this meeting the participants continued to be very animated in their participation.

> “It’s [the PAR process] been the most amazing, positive thing I’ve [caregiver] done for a long time”. [Advisory group, meeting two]

Participants often talked over each other in their enthusiasm, which meant that getting a verbatim transcript using a single audio-recorder, was difficult. Their enthusiasm needed some guidance in this meeting as some of their suggestions were outside the scope of what could be achieved without dramatic changes in financial investment in the service, for example, substantial increases in staff numbers on shifts. JP needed to ensure a balance in encouraging their enthusiasm and being mindful that if the suggestions were unaffordable and unachievable the process could be undermined, as it would not be realistic to expect support for these from management. Having prior experience in the aged care sector was an advantage in achieving this balance as illustrated in the comments below.

P: “And sometimes you can’t find your other half [a shift colleague].”

P: “Some of them are terrible.”

P: “And there’s no— nothing happens, aye. It’s just allowed to happen. And it’s very frustrating—“

P: “Well I actually timed one person who was in doing one of the residents, and was watching, and she was watching TV. Wasn’t even chatting with the resident.”

JP:” Which then if you had a senior caregiver role, and also the RNs were clear about it, you could go to the RN and say ‘You need to fix this. You’re in charge of the shift, I’ve just watched this happening, can you go and do something about it?’ ’Cause otherwise, if they’re sitting there, your colleague, or whoever else is left to pick up all the work.”

P: “Exactly. And everybody else is busting their gut to do the work while one’s sitting there, and that happens an awful lot.”

P:”And it wouldn’t hurt, I might run out of wipes, and I’ve done their room and I’ve run out of wipes, so you girls know what I’m talking about but because I want to get to the next person to keep to my timetable. I have to think of that, I write their name and what I need, so when I’ve got everybody done, I can go back and say ‘oh, I need to get this, this, this, and this.” [Advisory Group, meeting two]

#### *5.2.1.3 Meeting Three*

In the third and fourth meetings, the advisory group focused on the detail of the action plan to be developed by the participants. After the second meeting JP wrote up the ideas put forward by the participants into a draft action plan. This draft was reviewed by the group at the third meeting and changes made to confirm the final version that was presented to the managers. In this third meeting it became clear that unbeknown to JP the participants had decided to take the draft plan to the wider organisation and showed it to several staff who were not members of the advisory group. These staff included registered nursing staff, other caregivers, kitchen staff, and administration staff.

“(. . .) showing it [action plan] to the RNs, and you know they were just so enthused about it too. It’s wow, we’re actually working on the same page here.” [Advisory group, meeting three]

This action by the advisory group highlighted the dynamic nature of PAR and the flexibility required by JP. Fortunately more staff being aware of the developing action plan had a positive impact; the profile of the research was raised within the facility, which assisted with future recruitment. Although awareness of the research was heightened across the wider facility, this was observed by the advisory group participants to have stimulated some dissatisfaction from other caregivers who expressed this as a missed opportunity to participate in the work. It became clear that the advisory group chose to manage this dissatisfaction themselves by responding positively to anyone who asked about the research and its progress.

“I mean I’ve been talking to other staff, and they all seemed a bit reluctant, and the comment was made to me yesterday ‘well I hope other caregivers are having input into this.’ And I said ‘well you had the opportunity to join it.’ And there will be on-going opportunities, everybody was invited to come along, I was really disappointed it was such a small group, [advisory group] but then sometimes a smaller group can be easier.” [Advisory group meeting three]

At this third meeting the participants not only finalised the draft plan but also discussed how the plan would be presented to the management representatives. Initially they were concerned about taking their ideas to management as they had never done this, and they were anxious that they might not be taken seriously. However, they quickly concluded that this would be a constructive opportunity and were reminded that it was an agreed part of the research and had full management support. This reassurance was well received and they confidently proceeded.

#### *5.2.1.4 Meeting four*

At the fourth and final meeting in Step One, the advisory group presented the action plan (Table 5.4) to the facility manager and nurse manager in a specifically organised meeting.

**Table 5.4:** Action plan

| **Research Area** | **Actions (in priority order)** | **Expected outcomes** |
|---|---|---|
| 1.0 Build team work | 1.1 Regular monthly meeting for caregivers only with nurse manager | Provide an opportunity for caregivers to talk about key issues, and determine resolution |
| | 1.2 Reinforce role of RN as team leader of a shift | Provide shift leadership including more focused handovers, equitable allocation of residents, walk around before shifts start to ensure all issues handed over. |
| | 1.3 Teambuilding workshop for all staff<br>(N.B) could be at the monthly staff meeting | Provide understanding of what it means to work in a team for all staff. |
| | 1.4 Develop senior caregiver role | Provide clinical leadership for caregivers as this person would provide support for caregiving skills development, consistent standards of care, be the coach and mentor for caregivers |
| | 1.5 Role task sheets for all roles where tasks overlap | Provide clarity of tasks required in each role e.g., kitchen staff and caregiver over who clears the table |
| | 1.6 Use rotating rosters more often<br>(N.B. This may have some buy-in issues that may make implemention difficult) | Provide opportunity for all staff to experience each shift and the workload |

| | | |
|---|---|---|
| 2.0 Achieve more time with residents | Some of the actions above will also assist in achieving progress in this area e.g., 1.1, 1.5 (allocation), 1.6 | |
| | 2.1 Review all staff ratios | More staff would allow more time to spend with residents. In recognition that this is a resourcing issue it is suggested that this is started by a review of the night staff caregiver ratios rather than all shifts |
| | 2.2 Provide opportunity for learning time management skills (N.B. could be at the monthly staff meeting) | This would enable those staff who struggle to get routine or structure in their shift to learn new skills to help manage the workload. |
| 3.0 Provide opportunities for professional development | 3.1 Review of the performance appraisal process and form | Encourage more constructive feedback and timely appraisals |

Further consents were obtained at this meeting from the management staff. JP gave a brief introduction and then the advisory group participants worked through each of the actions in the plan with the facility manager and the nurse manager. It was important for JP to be flexible and allow the participants to present the plan in their own way, which was somewhat detailed and tended to focus on issues for specific residents rather than strategic actions as illustrated in the comment below.

> P: "For an example, I was told last week, because I'd been using like the fatty cream, which is on the care plan,[for a resident] and then it was told to me 'no, use the zinc and castor oil.' And then this week—"
>
> P: "That's the first I've heard of that one."
>
> P: "No, that's what I was told last week, and I thought 'well I've been doing the care plan' you know, following the care plan, and 'no, no, no. Do this, this is what D [the RN's] been doing. And then this week it's 'no, no, you don't do that,' and 'no, [the RNs] not doing it.' And I said 'well, who am I supposed to listen to, I listen to each RN that I'm working with,' but I'm getting different stories, so."
>
> P: "Very frustrating."
>
> P: "It is very frustrating."

> P: "Well I think I did mention that, at one of our handovers, 'cause I was getting quite annoyed because he's got so many creams in there. And on his care plan he's only supposed to be using the fatty cream, the betamethasone, for his legs, and the miconazole, for his groin area. And yet he's urea, zinc and castor, you know, that should not even be there if that's not on his care plan. I think whoever's on night shift then comes on and is confused."
>
> P: "And then I was told that even the lotion was being put on his legs, and I'm thinking 'my god, that's for his scalp.' It actually says it's for his scalp. And there's so much— and you're hearing different things. But it's also, you know, having that senior caregiver, if they're working, they're actually encouraging the people that are working, because some are working really, really hard, and some are not." [Advisory group, meeting four]

But when they were able to articulate on actions that were broader than detailed residents' care this in their presentation they were very clear about what they wanted and why. The quote below illustrates how they described the value for them in having caregiver-only meeting.

> "It's [caregiver-only meeting] also an opportunity that if we've sort of got ideas and things like that, you [nurse manager] can talk to us about it, and explain it, and there's a bigger group of people actually taking part in it. At the moment with the staff meetings, there's not always a lot of carers there. And quite often issues that are bought up aren't actually even in the minutes. And there's no follow-up outcomes from those issues that are raised, so this [caregiver-only meeting] would actually focus solely on the care, you know, the residents and the caregivers. And if there's an issue also with things not being done, or, you know, stuff like that, that to just have the caregivers at the meeting I think it would be quite valuable." [Advisory group, meeting four]

As the management staff members were encouraging and actively listened, the advisory group successfully completed the presentation of its entire plan. The process enabled the participants to gain confidence as they experienced being listened to and valued for their contribution. Their experience was further validated when the first action in the plan was accepted in the meeting – the establishment of a caregiver-only meeting – and a date made for implementation. Other actions were to be considered by the managers and decisions made about the timeframe for implementing them.

### 5.2.2 Step Two – Act (implementing the actions)

Although it was considered in the initial protocol, additional recruitment for Step Two was unnecessary. This became clear when it was decided that the main action to be implemented was for the facility management to hold a caregiver-only meeting, which they agreed would be a routine part of the facility's service delivery. The researcher attended four of these meetings as an observer. The meeting process and content were recorded in field notes by JP, observations without details of content, for example, resident or participant names. At these meetings some detailed clinical issues were discussed that were not relevant to the research question but the observation of the process was relevant. The caregivers also kept minutes from these meetings that were available to the staff and JP. Audio-recording was not possible as confidential clinical details about individual residents were discussed and not all staff attending had prospectively agreed to consent to recording.

In Step Two, some of the actions from the action plan were implemented in the facility. The actions chosen to be implemented were determined by the facility manager who made the decision based on available resources and impact on the functioning of the facility. There was a commitment from management to implement all actions in future but a recognition that these needed to be phased in as resources allowed. Specifically, the first actions identified in the caregiver-only meeting to be implemented were: 1.1 Regular monthly meeting for caregivers only with the nurse manager, 1.2 Reinforce role of RN as team leader of a shift, and 1.5 Role task sheets (i.e., a written document to describe in detail the tasks that needed to be completed by a caregiver on a specific shift) for all roles where tasks overlap. The advisory group determined the caregiver-only meeting was the highest priority as it believed this would have the most impact on caregivers' work. This proved to be the most influential action in the plan and was the process through which the next two actions were implemented. The monthly meetings were held in the staff room at the facility and became a normal part of the facility meeting timetable. They continued as part of the facility meeting timetable after the completion of this research.

The other two actions from the action plan that were implemented at Step Two described developing RN leadership and creating task sheets. These actions were initiated in the caregiver-only meetings and then taken to the wider facility. For example, the minutes from the meetings were shared with the RNs by the nurse manager as an agenda item at their RN meeting, so they were aware of the specific issues that were raised and the solutions the caregivers had suggested. Some task sheets were developed by participants who wrote up a draft outside of the meetings then presented it back to the meeting as an agenda item. Once

the task sheets were developed and presented to the relevant caregiver-only meeting they were signed off by the nurse manager, who attended every meeting. An important part of the implementation of this action was having the nurse manager attend the meetings. This supported the recognition of her authority and the reality that she had access to resources to support the caregivers' ideas being implemented in the facility.

The initial research protocol proposed that the advisory group of caregivers be expanded through a purposeful sampling process to include others who would implement the actions in the plan. However, the type of actions they identified and the decisions by management meant that the plan was implemented across the facility and included all caregiver staff. As it was part of their service delivery all caregivers were included in the implementation of the actions. The caregiver-only meetings were open to all caregivers and advertised internally on the staff noticeboard as well as by word of mouth to enable everyone to attend. As noted above, the meetings were not audio recorded nor were additional consents obtained as they were part of the facility's meeting timetable. The caregivers who attended were mostly the advisory group members with a couple of other colleagues. The meetings had 10 attendees (50% of the total caregiving staff) at the first meetings with half that number attending the other three that JP observed.

The caregivers very quickly took charge of the meeting and were happy to set their own agenda and take the minutes. They were observed to be identifying issues, problem solving and then validating their colleagues for their solution as identified in the example below.

> "J [caregiver] has suggested a duty work sheet that would be useful for identifying what the residents' general status is and enable recording of pertinent information re allocated residents for recording later in the notes. Example from AH [another aged care facility] provided. D [caregiver] has kindly typed up a similar sheet for us – tabled at the meeting. All agreed this will be helpful. L [nurse manager] will progress and make available." [Action recorded in minutes from the caregiver-only meeting held on February 14 2017]

The value of this process for the caregivers was supported by comments made in the evaluation interviews and suggested that this was an important opportunity for them to contribute ideas to their work environment.

> "And a comment was made to me, you know, 'why do you have to have these [caregiver-only] meetings?' And I went home this day and I thought about, and I actually come back and told this person that they'd upset me, because you know (. . .)

> we have kitchen meetings, we have cleaners' meetings, and (. . .) I says 'you need to know that we actually matter too.' And that was— I think that was one of the biggest feelings that we had, that we didn't matter." [Advisory group, evaluation interview]

The meetings have continued to be held in the facility but with variable numbers of caregivers attending. As they see value in these meetings the advisory group members and nurse manager are exploring ways in which they can increase participation.

### 5.2.3 Step Three – Observe (evaluation of the actions)

Observing the implementation and consequences of actions from Step Two was the next part of the research process. Six semi-structured interviews, an hour in length, were held with a variety of participants. The aim was to understand how the PAR methodology had been experienced, whether any change had occurred and what, if any, improvements could be made to the process. A schedule of questions (Appendix 7) was developed by JP and research supervisors to be used with each interview with encouragement for the interview participants to expand on their own ideas in each interview. Response to the interview questions reflected the different ways that each participant had viewed the PAR process. For example, the management participants (facility manager, clinical manager, and quality manager) found it relatively easy to reflect on the process and consider the wider implications of the research as indicated in the comment below.

> "Yeah. But on the other hand, we've somehow got to find a way to readdress the balance, and that's about political motivation for doing that. And in many respects, you know, I think the research is quite pertinent from that perspective as well. 'Cause that's about a workforce growing and developing. A workforce that's going to have-to deal with greater complexity in the future, you know, we're finding that the level of need, and complexity around some of them now coming in, even at rest home levels is greater, it's higher. People are not coming into facilities now til well down the line. And you know, effectively we've had a relatively — a low-paid, relatively untrained workforce, to deal with that. And that's just not good enough, you know." [Facility manager evaluation interview]

Whereas the advisory group members, other caregivers and nursing staff found this more difficult and tended to focus more on tasks achieved or clinical issues relevant to individual residents.

> "I'll just give you a little example; I head the falls prevention group. So we gather all the information from the month before, and at the next staff meeting we talk about it.

> We talk about it as a whole staff and we evaluate why that person [fell]. Probably a year, or maybe 18 months ago, people [caregivers] would have just not been 'oh, you know, he had a fall'. Now, they actually say 'well do think it would be better idea if you . . . .' They really engage as to why that person could [have] fallen, and what we can do to stop [falls] 'Well should we put a sensor mat in their room?' So that really it [PAR] has been a really good learning thing for everybody actually." [EN/RN, evaluation interview]

The participants in Step Three were chosen to enable a broad range of views from the facility, wider than just the advisory group. The participants all spoke freely about their experiences and the changes they noticed during and as a result of the PAR process. Their comments were mostly supportive of the PAR methodology and its role in the changes they had observed. The verbatim comments provided evidence of the positive impact this process had on enabling engagement by caregivers.

> "What I've noticed that's different. I guess there's a lot more talk (…) (. . .the home assistants [caregivers] are more likely to say what they feel, and what they're thinking, and what's not working and what is. There's been more staff come to staff meetings." [Nurse manager, evaluation interview]

Some of the comments suggested that the impact of the PAR process was not limited to the caregivers. It was noted they had observed other workers also demonstrated improved participation in meetings and discussions, including kitchen and cleaning staff. This was attributed to the other staff seeing the value of caregivers designing their own meeting and providing a place where they felt they could be heard and could contribute to the workplace.

> "Yeah, I mean there's always been a kitchen meeting (. . .) but I think that's grown legs. I think with cleaning staff there have been meetings, it's definitely grown legs, and I think having the home assistants actually involved in their own meeting that was a first. And that was a really good step . . . I think one does impact on the other. You know, 'cause everybody's on the floor. And their roles might be different, but they're all there, you know, with the same aims and intents really." [Facility manager, evaluation interview]

While the interviews in Step Three were mostly positive in their view that the PAR process enabled improved engagement, some participants did express criticism about aspects of the work completed. These comments tended to indicate areas for improvements for future research design, for example, some participants commented that a wider group of staff could

have participated in the meeting where the action plan was presented, not just the two managers. They commented that this would increase awareness as to why actions from the plan were needed, especially the caregiver-only meetings. Consequently this would have improved support for these actions from the wider workforce.

> P: "But in saying that, everybody had the opportunity to come to your group [advisory group]. And apparently they showed the plan around all sorts of people. So they told me, they had the plan out there and people looking at it."
>
> P2: "And they did."
>
> P: "Yeah. But that's as I said before, you know, it's easy for people to not go to meetings, and then when something is implemented they think 'oh, well, I'm not going to do that, it wasn't my idea."
>
> P2: "Which is unfortunate." [EN/RN, evaluation interview]

This potential lack of support was also evident in the interview with nursing staff who commented that they had limited knowledge of the process and while they could describe changes in the level of engagement by caregivers, they did not acknowledge this as a result of the research process as they felt it did not reflect the whole facility.

> "Just from observation I'm not sure whether that really three caregivers is a good indication on how, you know, how everyone is feeling, or working as a team. That's just how I see it. Would of [sic] been really good to have eight care givers there. At a meeting, you know." [RN/EN, evaluation interview]

These staff, however, had not been part of the presentation of the action plan by the advisory group and although some had seen it informally, they indicated that they would have liked to have been more formally involved in understanding how the actions in the plan had been developed and what was suggested would occur in the next step.

The quality manager also expressed that she had been somewhat sceptical of the PAR process in the initial stages. She felt the caregiver-only meetings would take time away from their work with no added value. However, she acknowledged that from her observations and discussion with staff she had changed her mind and now agreed that the caregiver-only meetings had added value in terms of increased engagement and consequently, in her view, improved resident care.

> "Yeah well it's quite good for me too, and it's good for you [researcher] to hear, that I was sceptical about it, not terribly, but a little. And I can see the advantages, so that's a good thing, isn't it? [Quality manager, evaluation interview]

The flexibility of the process about meeting frequency, time, and place, while at times frustrating for JP, had been critical in ensuring that the data collected reflected the participants' experience rather than following a more rigid process. Without their full participation there might not have been the same opportunity to collect data that provided an understanding of how to enable caregiver engagement.

As part of the evaluation of implementation of the action plan the initial research method included an intention to collect targeted data on service quality from the facility's internal audit process and to collect these data before and after the completion of the PAR process. However, as the PAR process progressed, and in discussion with both the facility manger and research supervisors, it became clear that the available audit data would not meaningfully reflect the changes that had occurred as a result of the caregivers' action plan. This was because the audit data had been collected for other purposes, and did not include data related to the work of caregivers at a sufficiently nuanced level. For example, the internal audit involved the collection of incident data, number of resident falls, and training sessions attended by caregivers. Consequently this part of the proposed method was not used.

The facility did achieve four years certification (the highest possible) in their external audit following the commencement of the PAR process, the research project being recorded as a continuous quality improvement initiative contributing to service quality in the organisation. The report from the DAA Group Health Auditors who conducted the audit, published on the Ministry of Health website, indicated that Carter Court Rest Home had exceeded the audit requirements to meet Criterion 1.2.3.5 "Key components of service delivery shall be explicitly linked to the quality management system" (Ministry of Health, 2013). Very few continuous quality improvements are accepted by the Ministry of Health as part of the ARC audit process, with many facilities never able to achieve this level of quality improvements, as can be seen in the database of audit results published on the Ministry of Health website (Ministry of Health; 2013). Actions to achieve continuous improvement can include work done in health and safety or enhanced consumer participation. Thus, it was a significant achievement by the facility to be recognised for the PAR research work they were doing to develop an understanding of the engagement of caregivers in their workplace.

### 5.2.4 Step Four – Reflect (feedback on the results)

The first three steps in the PAR design resulted in 146 pages of transcribed interviews, plus seven pages of field notes and observations, a poster advertising the initial meetings, four pages of meeting minutes, and two emails confirming the process for one of actions in the action plan. This information was analysed and synthesised into an explanatory model (described in detail in section 5.3), and presented to the facility staff in Step Four of the PAR process. This process enabled JP to give feedback to the facility staff on the results of the study, especially the model that was developed, and provided opportunity for the staff to comment. The meeting was held on a day and time that suited caregiver shifts and was available to any staff who wanted to attend. Seven staff attended the meeting – four caregivers (two from the advisory group and two others), two managers, and one registered nurse. Although this was a numerically small attendance there was good representation from all staff roles across the facility. Initially JP planned to deliver a formal presentation but, as occurred throughout the research process, the projector and screen required for a formal presentation was not available, nor was a suitable meeting room, and to add a presentation to a staff meeting was not possible as they had a full agenda. The feedback meeting was therefore held in a vacant residents' room with a whiteboard and the participants were given a printed handout of the draft model. The meeting lasted for an hour with plenty of contributions from participants.

The meeting at Step Four was not audio recorded as it included participants who wanted to attend but had not given written consent to the research process. The data from this meeting was collected by noting key ideas in field notes recorded by JP. In addition, the intent of the meeting was to collect the general comments and perceptions of participants rather than their detailed responses. The field notes were confirmed as an accurate record through later discussion with the nurse manager who attended. The comments were positive about the process but also constructive in their criticism with suggestions for change in future research design. These comments reiterated those reported in Step Three.

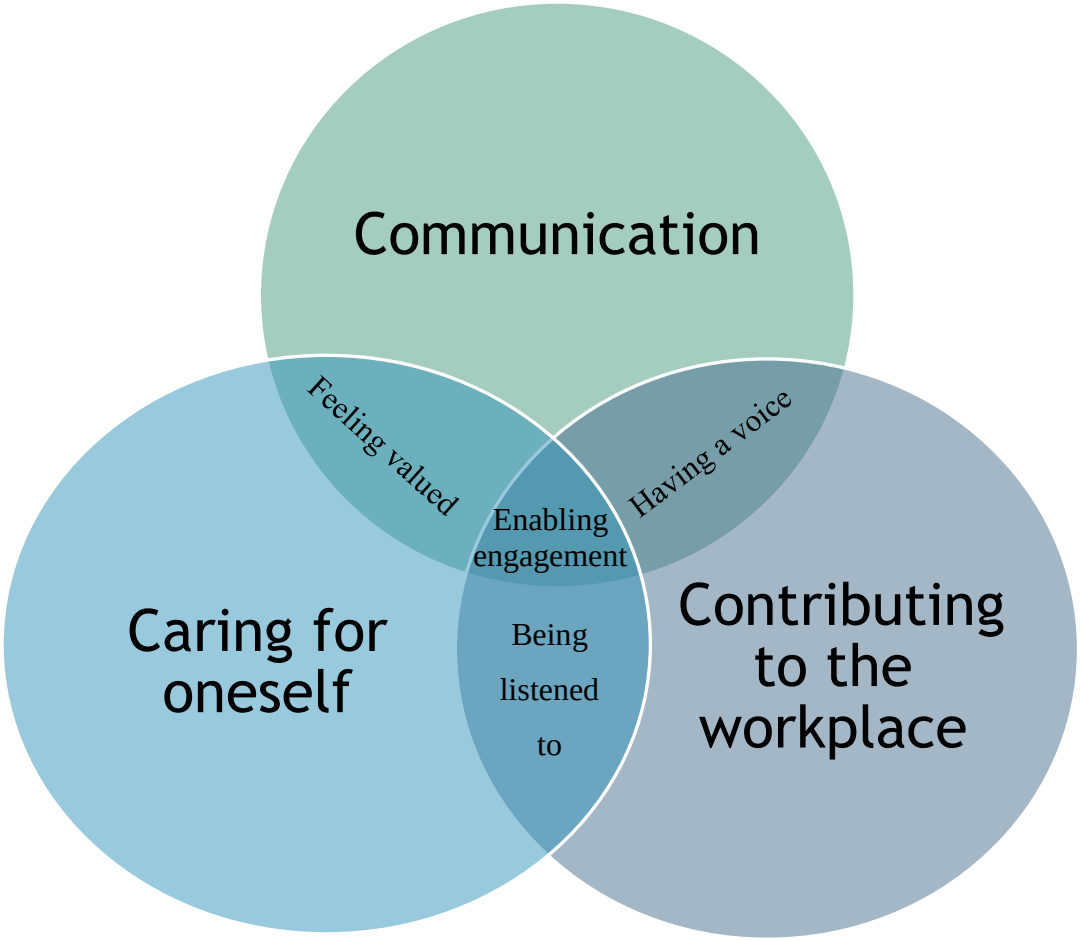
In summary, this fourth and final step was an opportunity for staff to reflect on how this year-long collaborative research process had been experienced, from the recruitment of participants to the collection of data, which resulted in the development of a model that described how caregivers can be engaged in their work in ARC. They readily understood the model and agreed that it gave insight into their work in a way that was easy to understand. Perhaps most profoundly, they all believed that this research could have implications for the wider ARC sector in that other facilities could use the model to reflect on and develop the quality of their

work and support for caregiver staff. The remainder of this chapter focuses on the model of ARC caregiver engagement that emerged from the PAR process.

## 5.3 A model to enable ARC caregiver engagement

A model describing how to enable caregivers to be engaged in ARC services was developed from the analysis of data obtained throughout the research process. This model provides a diagrammatic representation of how caregivers can be engaged in their work and their workplace. The model included three influencers (this term is used to define aspects that influence engagement) and three interlinking experiences (this term is used to define the experiences that support the influencers to enable engagement) for caregivers. The three key influencers were; (1) Communication, (2) Contribution to the workplace, and (3) Caring for oneself. The key experiences arising from the intersection of these influencers were: (1) "being listened to", (2) feeling valued" and (3) "having a voice". This model provides a guide where workplace initiatives can be introduced to enhance caregiver engagement in the workplace. Each part of this model is described in detail in the following sections.

**Figure 1: Model for enabling workplace engagement by ARC caregivers**



### 5.3.1 Communication

Communication was described by the participants in the first advisory group meeting in a very comprehensive way.

> "Communication has got to be on every level, and it's got to be across the board so you know, if it's not set in concrete, so this is what's got to happen, and not somebody passing the story on, cause then it gets changed every time it gets to a new person. It needs to be clear, so that everybody even if it's written out, and say this is what we would like to be done, this, this, and this, and everybody knows that's what's meant to happen." [Advisory group, meeting one]

In this context the participants referred to work-focused communication and did not include the social communication that occurred in informal settings such as meal breaks, or the communication given through education sessions. The mode of communication was mostly informal and verbal, but did include more formal written communications such as the information provided in handover notes, task sheets, and the writing of progress notes in the residents' care plan. The written communication, for example, handover sheets and care plans, were essential to ensure all staff had relevant information to do their job well.

The participants identified three main opportunities in which work-oriented communication occurred – between caregivers on the same shift, between caregivers on different shifts, or between the caregivers and the RN on duty, in addition to the more usual formal meeting environment such as staff meetings. The participants acknowledge that all facility meetings were important for them as mechanisms where they could discuss areas of concern, including allocation of workload or resident care issues in their workplace. They described how positive the experience was when they were given the opportunity to develop practical solutions to issues identified by them as a workforce.

> "Where caregivers actually get to talk about concerns about the different residents, and that there's the communication on how we can improve it. You know (. . .)you might have an idea yourself, but when you sit around as a group, you can work out ways, and everybody's got ideas, and the more people are able to talk about their ideas, the more enthusiastic they are about you know, participating in it." [Advisory group, meeting one]

#### *5.3.1.1 Communication between caregivers on the same shift*

The first of the three opportunities for sharing information occurred outside meetings and was described as the communication that occurred between caregivers on the same shift. This opportunity they indicated specifically assisted in managing their workload. For example, a staff member on the same shift might need help with a task or might have identified an issue that needed to be resolved.

> "But I think it's also the communication. So that if you're tied up with situations, that you actually let your team mate know, 'I'm going to be a bit tied up here,' so that that actually, you know, gives them the feeling that 'well I can help out, I can get that bell because she's busy, needs a bit of time with that person,' or something like that." [Advisory Group, meeting two]

If they received help to complete the task or solve an issue, then the shift was more positive and they were more engaged in their work. Not only did this form of communication require time for it to occur, that is, the opportunity of a moment to talk to other caregivers but it also required a level of trust and confidence in the relationship, that is, the confidence that the issue would be acted on. Those who had worked together for some time or who developed a strong relationship found this easier than those who did not get along well or who had not had sufficient time to develop common understandings and relationships.

> P1: "And it can work because look at Saturday for example, we were really short, the whole lot of us, there was only us four girls on (. . .) and the whole of us all just worked in together, like one little happy family."
>
> P2: "I heard about it, and it was amazing."
>
> P3:"I tell you (. . .) it was an amazing day, it was a busy day and a really hard day but I'll tell you what, we had a good RN on that day, and everything (. . .) it just flowed." [Advisory group, meeting four]

However, when they talked about the importance of communication between those working on the same shift, the participants also commented that they tried to do this regardless of any relationship difficulties they might have.

> "The girls the other morning were sort of going on, you know, 'we're so, so busy, we're so, so busy,' and I said 'you girls need to stop saying that, and focus more on the safety issue, and the cares of the residents.' You know because you need to

> change, you know, like, change your mind set, change the way you think." [Advisory group, meeting two]

For some caregivers, having confidence in one's colleagues was a key part of successful communication. This made the caregiving shift a positive one and demonstrated the level of their engagement in their work. This confidence could be at an unspoken level of knowledge sharing or when a more explicit verbal exchange occurred that determined the tasks required to deliver care.

> "Like I got R [caregiver] today, and I tell you, I love working with her. Because I don't tell her what I'm going to do and she doesn't tell me what she's got to do, we just go, it's just we know what we're doing and we know (. . .) where we need to be [and if] a certain person needs two people [for assistance]". [Advisory group meeting one]

This more explicit verbal exchange was especially true when they experienced situations that added to the workload, for example, lots of call bells being rung at once.

> "(. . .) it's also the communication. So that if you're tied up with situations, that you actually let your team mate know, 'I'm going to be a bit tied up here,' so that that actually, you know, gives them the feeling that 'well I can help out, I can get that bell because she's busy, needs a bit of time with that person' or something like that". [Advisory group, meeting two]

#### *5.3.1.2 Communication between caregivers on different shifts*

The second opportunity where the participants indicated that important work-related communication occurred was when information was passed on between caregivers on different shifts. They linked this to the quality of care they provided, in particularly consistency in managing resident care. These handover meetings usually occurred at the start of each shift and involved all staff about to start their shift as well as one or two of those about to finish the shift. This meeting occurs in all ARC facility with the purpose being to hand on any information relevant to resident care both written and verbal, to the next shift. Of note, the participants in this study reported that time management in these handover meetings could be a challenge, with some effort required to help staff stay focused on core business.

> "It is, you know, like with the handover. Handovers can be drawn out, people start going back to what happened ages ago. And I mean I noticed this morning we were

> still sitting at handover at ten past seven, well, the girls should have been on the floor at seven." [Advisory group, meeting one]

If this communication does not occur, caregivers are less able to deliver care to a standard they feel satisfied with and consequently can become less engaged in their work. The consequences can be significant for the resident and for the staff member, as in the example below that occurred in a routine handover meeting and showed the importance of sharing knowledge to enable the caregiver to deliver quality care. In this example a resident appeared to be making his own bed, so the caregivers did not think they needed to do that task. One caregiver discovered that he was simply pulling up the bedspread over wet sheets and this information was communicated at the handover meeting to the caregivers on the next shift. They were asked to check to be sure the bed was properly made with clean sheets. This was also quite rightly identified as a potential health and safety issue for the resident.

> "And when I mean about communication is I said in health and safety meeting, every caregiver has got to go into his room, and check the bed, every morning. Because—and if that's not handed on, because if I hadn't said about it being wet, I would have thought Mr D [resident] had made it. " [Advisory group, meeting one]

As with communication between staff on the same shift, communication between staff on different shifts also required a level of trust and confidence that issues could be raised and in turn would be heard and acted on. To develop this increased trust and understanding the advisory group suggested rotating shifts, that is, working morning, afternoon, and night shifts – not just night shift. This action was identified as a specific action in the advisory group's action plan which was presented to management – "1.6 Use rotating rosters more often (N.B. This may have some buy-in issues that make implementation difficult)" (Table 5.3). The advisory group proposed that by implementing a rotating roster that gave caregivers the experience of working on different shift. This would enable caregivers to gain an improved understanding of the workload and priorities for each shift.

> "This is what I'm saying, is that the morning girls need to stop bitching about what's going on, you know, about tasks not getting done on the night shift, 'cause you don't do the night shift, so you don't know what they have to do." [Advisory group, meeting two]

The participants in this study suggested that this change to the roster process would help staff identify what information was most vital to be passed on during handovers, but they acknowledged it had potential implementation difficulties.

> "Well I think a lot of communication gets missed because like you had your shift last night, we go our shift today, and then the PM [afternoon shift] comes on, and information's not getting passed through all the shifts. And another thing, I know everybody will kick up a stink, but I think it actually works, rotating shifts." [Advisory group, meeting one]

The participants identified this was a potentially controversial suggestion as many caregivers are employed to do the same shift every week, for example, four morning shifts each week, unlike registered nursing staff who are routinely employed to do rotating shifts. If they worked the same shifts each week rather than rostered shifts, staff had some certainty regarding their work commitments, and this helped with managing family and other commitments outside the workplace. Consequently, changing to a more flexible rotating shift pattern would not necessarily be well received by all caregiver staff, even though the requirement of advance rostering does give some degree of certainty. The nurse manger agreed this was an action she would explore for implementation in the future rather than immediately as it required changes to the existing rostering process and could not be easily implemented without the support of staff.

#### *5.3.1.3 Communication between caregivers and RNs*

The third communication opportunity the participants identified was the passing of information from the caregivers to the RN. The participants in this study indicated that this communication could also be verbal or written but usually focused on an aspect of resident care. It was seen as important not only for the continuity of care of residents, but also for supporting the leadership role of RNs. The RNs are the shift leaders and in this role they are expected to ensure that each shift runs smoothly. The caregiver participants were very clear about this and could describe this leadership role both in a generic, theoretical sense and a more detailed behavioural sense.

> "Yeah, some of them are more supportive, some of them are more communicative than others. They [RN] actually need to take that lead role." [Advisory group, meeting one]

> "And then you quite often hear when I've [caregiver] said things haven't been done [RN says] 'oh well they should know what they're doing by now, I shouldn't have to check.' And excuse me, but you're [RN] the team leader, you're actually in charge of that team, you're in charge of that shift. It's up to you to make sure that everything's working properly." [Advisory group, meeting one]

Communication with the RN was regarded as of such importance to the participants that they identified the development of RN leadership as a detailed action in the advisory group's action plan presented to management – "1.2 Provide shift leadership including more focused handovers, equitable allocation of residents, walk around before shifts start to ensure all issues handed over" (Table 5.4).

As with the other two communication opportunities identified, the effectiveness of this was influenced by the relationship the RN had with the caregiver. If it was a positive relationship underpinned by trust and confidence, then the caregivers would engage in useful communication and this effective communication would add value to the work place.

> "And you knew you could go to her, you go to her and say 'hey look, this isn't being done,' or she would actually work [it] out and I notice some of the newer RNs are actually checking the roster and they're actually seeing who was where, and you know, trying to address these situations. But she [RN] would actually just take that person [caregiver] off and have a quiet word. "[Advisory group, meeting three]

In addition, if the relationship was positive the communication was also very supportive of the RN role.

> "Like when Mr B[resident] had a fall, and (. . .) the bells [call bells] were going, and there was all the other jobs (. . .) I actually just got everything ready for the nurse, and then said 'are you okay,' because you know, there was so much else, and then I went back and she's got blood all over her hands and I thought 'so how is she going to get everything'. So I just run down and got more stuff, and I laid it all out on the table, but I had to keep running, you know, to do everybody else. Well, she actually needed assistance with that job." [Advisory group meeting two]

If the relationship was not positive and the caregiver did not trust the RN or believe that they would be listened to, then they would not communicate with them as effectively. When this lack of communication occurred, they described this as seeming to be less engaged in their work.

> "They [RNs] quite often think that they're here to do the pills, and do the dressings and that, but they actually lead the team of caregivers. And that [RN leadership] would actually improve the teamwork, you know, to have that working." [Advisory group, meeting three]

Passing on information, sharing knowledge, and problem solving often occurred together. For example, in the caregiver-only meetings observed by JP, the caregivers would put forward ideas or identify problems with a particular resident's care or a task they needed to complete, which were then passed on to the RN meeting. For example, in the first meeting one of the caregivers expressed a view that there was no time to read care plans, so suggested that specific creams or other topical medications or continence products used for particular residents could be written on a form on the inside of their wardrobe. This was agreed by the group as being a good way for all staff, especially those who work casual shifts, to know how best to provide this very personal level of care to a resident. This example, as noted in observations made by JP, went to the RN meeting and was implemented by an RN delegated by the nurse manager to ensure the action was followed up.

> "Participants reviewed issues from last meeting including actions that have been implemented by caregivers and RNs, i.e. forms in wardrobes, duty sheet for handover, use of communication board in staff room, good response to medi-map process [medication dispensing process] for second checker".[Field notes from 15 March caregiver-only meeting]

As in this example the caregivers used the discussion in the meeting to come up with ways to solve the problem. This often involved lengthy discussions to identify the issues and then multiple ideas for potential solutions coming from a number of people.

The participants were observed by JP in these meetings to validate those who had contributed ideas by acknowledging what they had put forward, often in a very direct way, for example, thanking them for their input, using names in the minutes so people were identified as having constructive ideas or solutions and reporting on the follow-up of actions from the previous meeting. This was demonstrated in the observed behaviour in the caregiver-only meetings

> "Participants observed to be validating each other, for example, held discussion on giving out morning water jugs and waking residents "You're doing well – keep it up".[Field notes from 15 March caregiver-only meeting]

Further validation of their participation occurred when the caregivers attending the meetings decided to be responsible for keeping minutes of the meetings as a record of the discussion. These meeting minutes also ensured that any outcomes were recorded that needed to go to other staff meetings, for example, RN or kitchen staff. In this way the actions could be tracked to ensure that they were followed up by someone.

> "I mean just from the last meeting, you know, issues that I raised at that meeting, and then (. . .) I had like four nights off, and I'd come back, and it's like "oh wow". A lot of the things that we talked about, something had actually been put in place, or something had been fixed. And it was such a positive feeling for me that you know; I mean you're not going to fix everything overnight, but to see changes". [Evaluation interview with advisory group]

This is an example of how the communication initiated by the caregivers was both clear and accountable. The implementation of the caregiver-only meetings, an action determined by the advisory group in the first step of the PAR, became an important forum in which the caregivers could communicate.

### 5.3.2 Contributing to the workplace

The second influencer, "Contributing to the workplace" refers to the opportunities caregivers have to contribute to how an ARC facility is run. The opportunity this research provided where an action plan was developed by caregivers in Step One was an example of the contribution they can make to their workplace. As well as the high level plan, this PAR study highlighted two specific mechanisms that enabled these staff to contribute to the workplace: (1) the opportunity to present ideas to management as an advisory group, and (2) the subsequent implementation of caregiver-only meetings that enabled them to become involved in quality improvement processes. These meetings gave the caregiver staff an opportunity to learn from each other and to put forward their own ideas. It became clear that for this influencer to be effective the caregivers had to feel as if they had permission to contribute their ideas. This sense of permission could be given by having an identified and agreed place to contribute, that is, a scheduled meeting. This was demonstrated in one of the key strategies that the advisory group recommended, and management implemented – the regular caregiver-only meeting. The monthly meetings quickly became the main forum for caregivers to make significant contributions to the workplace. Before this there had been a much larger staff meeting, which was described by caregivers as lacking the time and the opportunity to focus on the issues important to caregivers.

> "I've done it before you've even come to that meeting, and I've raised things and that, and I've virtually been told to 'shut your bloody mouth.'" [Advisory group, meeting two]

The participants suggested, in the evaluation interview in Step Three of the PAR process, that establishing these meetings had enabled them to be more effective in their contribution to workplace issues raised at the larger facility-wide staff meeting,

> "We've actually been able to, at the staff meetings, raise issues, concerns, not issues, but concerns, about you know, how we can run the floor effectively, and any changes that need to be made to make sure that we as carers are able to give the best possible care we can, you know, so yeah (. . .) it's [ PAR ] been great." [Advisory group, evaluation interview]

The participants contributed ideas relevant to the core business of the facility: the care of residents. The work of caregivers involves delivering care to residents and they contributed ideas about how the residents were allocated to caregivers. This was described as important for them as the allocation of residents to a caregiver impacted on how they managed their workload. The allocation of work usually considers the number of residents and their level of dependence and then allocates a number of residents to a specific person who would care for them. The process of allocation was done by RNs and was also regarded by the caregivers as an important way in which RN leadership could be demonstrated.

> "It's the leadership you know they actually need to be assertive. Setting that leadership, and 'right, this is how it's going to happen (. . .) you know the allocation of residents." [Advisory group, evaluation interview]

If the allocation was not done fairly, the participants believed that this could cause unequal workloads and a chaotic shift where no one was clear about who was responsible for which residents. If the allocation was fair and caregivers accountable for the care of specific groups of residents then the shift would go more smoothly for all staff.

> "When they [caregivers] come on duty, if they have their list of residents that they're caring for (. . .) it's not the same people doing the same showers, you've got some people that'll sneak off to do the easy ones and leave the harder ones for the other person. It's also making it easier for accountability. If you've got set group (. . .) you are responsible for the total cares of that person. So if you've got your set group, it might be say that wing, then you know that you've got to do all their cares and do all

> their work, and you're accountable and I think that could actually work a lot better."[Advisory group, meeting four]

It can be inferred that the impact of process of allocation of the residents contributed not only to the caregiver workplace environment but also to the workplace environment of other staff such as cleaners and kitchen staff. Chaos on the shift could create difficulties for cleaners who also have allocated tasks and need access to resident rooms to do this work, usually when the caregivers have completed their cares. Also, the kitchen staff needed to know if any residents required special diets, which caregivers could confirm after they had completed the residents' personal cares. The participants described how this could be done in an equitable way for them and therefore would have a positive impact for other staff in the facility.

The caregivers explicitly expanded their contribution to the workplace to include not just how their workload impacted others, but also how other actions were relevant to the quality of work provided. They demonstrated that they could see beyond their caregiving role to how other staff actions had an impact in the workplace. In the example below they demonstrated how they contributed to the wider management of the facility by their identification of a potential infection control issue where caregiver and kitchen-hand tasks overlap.

> "(. . .) the action would have to be that the kitchen, whether it be kitchen-hand whatever, the kitchen staff are responsible for clearing the tables. Because (. . .) there's more [of a] contamination issue with the caregivers doing it, than the kitchen staff doing it." [Advisory group, meeting one]

Other ways they demonstrated that they contributed to the workplace were when they asked relevant questions about the care of residents. Caregivers often developed a close relationship with the residents they cared for and as a result often understood the needs of individual residents better than any other staff, and through this understanding identified workplace issues relevant to particular residents.

> "I mean like the situation that K [caregiver] just mentioned with Mr P [resident]. So we've addressed the fact that he's making his own bed and he's turning it over and all the rest of it. So at the next meeting there needs to be an outcome. Has that improved, has the staff been taking more notice of what he's doing? Just saying, for argument's sake, like with Mr L [resident](. . .) these were the two that we've talked about, okay, so now that he's been – is he being checked each night before he goes to bed? Is that incontinence product in place? Is it working better?" [Advisory group, meeting one]

This research indicates that the influencer of "Contributing to the workplace" enables caregivers to be involved in decisions about workplace practice.

> "I think (. . .) the biggest thing is actually having part in the decision making. It actually makes you feel (. . .), it just makes you feel better." [Advisory group, evaluation interview]

This feedback highlights how this second influencer can have a positive impact on the motivation and engagement of caregivers in their work.

### 5.3.3 Caring for oneself

The third influencer in the model is "Caring for oneself." This aspect was not overtly identified by the participants in the development of their action plan but emerged through analysis of the data. The work the caregivers do is task focused and can be extremely demanding both emotionally and physically. This influencer helped develop an understanding of the importance of supporting this workforce to find ways to sustain themselves in this demanding role, which in turn enables engagement.

Caregivers, as with staff in any workplace, cannot do their work as well or as effectively when they feel burnt out or stressed (Bakker, Demerouti, & Sanz-Vergel, 2014). The work of ARC caregivers is with frail elderly people, providing physical assistance and emotional support to deliver residents' personal cares. The effective delivery of this care requires specific skills and emotional resilience, which are most effective when they are used in a caring and supportive workplace environment. The support of management to enable caregivers to take time to care for themselves will support this environment and was acknowledged by managers in this facility.

> "As I said, we've got an ageing workforce, some of whom are sick. And their colleagues are very concerned for them, and I think we [management] support those who are unwell as best as we can without criticism, you know. And I really appreciate that, but I think everybody's tired." [Evaluation interview nurse manager]

In this study, additional pressure was put on the caregiving staff in this facility as they had recently moved from rest home only to a combination of rest home and hospital level of care. As the residents become less mobile they often needed additional equipment for mobility, for example, hoists, which is time consuming and can led to a stressful shift. Also, at the time of this study the caregivers had an increasing number of frail residents, some with higher levels of dementia than the staff had been previously used to. Their care could require the staff to

take more time with each resident, which was sometimes challenging for the caregiver. To work with any resident required a high level of skill and emotional maturity; even for a resident without cognitive decline. It was sometimes exhausting for the caregiver to return several times to the same person while also trying to care for several others.

> "For instance I had one chap; he'd actually got himself up and got himself dressed. And he'd rung (. . .) he needed his shoes put on. And he says 'oh I'm so sorry, I know you're busy.' And I could have cried, I just said to him 'I wish I had the time'. I mean this man had got himself up and gotten dressed, all he needed help with was his slippers. And it's like you know, 'quick, just let me get them on, 'cause I've got three other bells ringing out there,' you know. And if you tell [another] one of the residents that 'sorry, I'm busy with the bells', she goes 'I want it now. I want to go now." [Advisory group, meeting two]

The participants in this study described the support of other team members as important in caring for themselves: specifically, being able to talk to other staff when they felt stressed about their workload.

> "Yeah. (. . .) you know this is what team work's about, it's like if you're feeling stressed, if you're feeling like you're being overworked, go and speak to your number one or two and say 'look, you know, I just need a break,' or 'I need a hand,' you know (. . .) cause I'm just feeling like this at the moment,' and you know, that's how it should be." [Advisory group, meeting two]

Another way the participants identified "Caring for oneself" as an important influencer was through their discussion about regular performance appraisals. These were identified as an action in the advisory group action plan presented to management – "3.1 Review of the performance appraisal process and form to encourage more constructive feedback and timely appraisals" (Table 5.4).

> "Well, I think our performance appraisals need to be looked at. We haven't had one since R [previous nurse manger]". [Advisory group, meeting two]

This workforce previously had very little workplace training, and no compulsory qualification was required for them to work. The participants were aware, however, that the importance of training for caregivers was recognised by the industry training organisation, Careerforce, as a requirement for improving the quality of care in the aged care sector. In this context, the

participants expressed interest in being able to participate in further training opportunities to develop their professional skills.

> "I've actually mentioned at quite a few appraisals, you know, it's been talked about, the training. Those things that you know, I would really like to get involved with, but nothings ever (. . .) it's sort of like gone in one ear and out the other. I'm dead set keen on getting my ACE training [a caregiver training programme] (. . .) and I would love to do my dementia as well. That'd be great." [Advisory group, meeting two]

The caregivers also indicated that they could take steps to care for themselves when these stressful situations arose. They knew the importance of looking after themselves in order to be able to continue effectively in their work.

> "I think— you know, all we really want is to be a happy family like we used to be, and have some help, and feel like were appreciated for what we do (. . .) giving each other a cuddle and feel like having a cry". [Advisory group meeting three]

This research indicated caregivers are better able to engage in their work and consequently able to perform in a physically and emotionally demanding role if an influencer "Caring for oneself" was present in the workplace.

## 5.4 ARC caregivers' experience of being engaged

Caregiver engagement in the workplace is summarised in a comment by the manager when reflecting on the impact of the PAR process as a whole.

> "There's more engagement and talking around the needs of residents. So when we do go through some of the residents' review aspects on the agenda, I'm picking up that there's more engagement." [Facility manager, evaluation interview]

When the influencers of "Communication", "Contributing to the workplace" and "Caring for oneself" were present, the participants described three workplace experiences: "feeling valued", "having a voice", and "being listened to". This section describes the experiences in detail to support how the model shows that enabling caregiver engagement in the workplace requires three influencers and three interlinking experiences.

### 5.4.1 Feeling valued

When the influencers of "Communication", for example, handover meetings between shifts; and "Caring for oneself", for example, asking others on the same shift for assistance were present the participants described how this gave them the experience of "feeling valued". In

this study the participants could describe ways of doing this that have been already noted and indicated that this experience had had positive impact on their sense of self-esteem and self-worth.

> "Yeah, they [Enrolled Nurse] do make me feel like I have actually done a good job and I'm not skiting there because I do know what I'm doing, but that's beside the point. She makes me [feel] and treats me like I'm worthwhile. " [Advisory group, meeting three]

The importance of this experience was perhaps most clearly demonstrated when the participants described what it was like not to feel valued.

> "And see, we never really get that. I raised a point in one of our staff meetings that care workers just feel like that they're, you know, (. . .) always being picked on, they're always being told what they're not doing, and what they're doing wrong, but not once are they being told 'good job,' or 'thank you'." [Advisory group, meeting two]

"Feeling valued" was described as being vital to how the caregivers believed they were regarded in the workplace. Some of the caregivers indicated that this was not a frequent experience and that they felt at times unable to participate in the workplace and therefore did not feel valued.

> "Because there's never really been any focus on the caregiving, or the caregivers. Caregivers are the lowest of the low here really." [Advisory group, meeting two]

The importance of caregivers feeling valued was discussed by the manager when reflecting on the positive impact of the research process.

> "What's been really good, you know (. . .) the whole aspect of (. . .) home assistants [caregivers] being valued and being consulted as part of the work team has been quite a significant development as well." [Facility manager, evaluation interview]

### 5.4.2 Having a voice

When the influencers of "Communication" (e.g., meeting opportunities) and "Contributing to the workplace" (e.g., meeting minutes) were actioned, this created the experience for caregivers of "having a voice". This experience was enabled through the opportunity to communicate (e.g., across shifts), as well as contributing ideas to improve the workplace (e.g., workload allocation). The experience was demonstrated when these workplace ideas

identified by participants were demonstrably acted on. The most obvious example of this was in the action plan developed in Step One. The implementation of the caregiver-only meetings that came out of the action plan was a key action for the advisory group. This meeting became a key opportunity to encourage this experience.

> "Yeah, so (. . .) we found that like with the meetings that we have with everybody,[staff meetings] doesn't give an opportunity for carers to be able to voice, or any issues that sort of come up, or it's, you know, quickly rushed, where we feel like, and there's also some carers who are shy about bringing up issues, because they're afraid that, you know, that they'll be either shut down, or they don't feel like they've got a voice, whereas I think, collectively as caregivers, being able to speak to yourself, within the group, they'd be more open to be able to voice issues." [Advisory group, meeting one]

The experience described by caregivers as having a voice was observed by two of the nursing staff in the evaluation interviews at Step Three of the PAR process. They were asked what they had noticed about caregiver participation in the research and they made the following comment.

> "(. . .) it has given them a greater voice, if that's how you want to put it, you know, they're not afraid to speak out (. . .) that forums [the caregiver-only meeting] there for them to say what they want to say and not feel that they're saying the wrong thing." [EN/RN evaluation interview]

This indicates that the meetings provided the place where the caregivers could experience having a voice. The experience of having voice required a mechanism to do this: that is, the caregiver-only meeting. In turn this encouraged caregivers to become engaged in their workplace, which they demonstrated in this study through contributing ideas for quality improvement, working in teams across the facility, and participating in the management of the facility.

### 5.3.3 Being listened to

When the influencers of "Caring for oneself" and "Contributing to the workplace" were present the participants talked about the experience of "being listened to". The participants were able to describe how this experience felt when they reflected on the PAR process and as in the example below, particularly the caregiver-only meetings.

> "So really, you know, the more [caregivers] that are there [at caregiver-only meetings] for that discussion, the better, you know. They can actually have a say. I actually feel empowered now that I'm actually having a say, and that I'm being listened to." [Advisory group, evaluation interview]

Some of the comments, as the one below, were interesting as they demonstrated the participants could identify what it was like when this experience was not present. They were quite clear that if they were not listened to they were demotivated and consequently less engaged in the workplace. This comment below was from one of the advisory group meetings in Step One before the implementation of their action plan.

> "And I mean I don't know about you guys, but sometimes you try and bring up things that concern you about cares for people, and then you just – get to the stage what's the point, 'cause nobody listens to you. And it's sad. It is very sad." [Advisory group, meeting two]

For "Contributing to the workplace" to enable the feeling of "being listened to" be evidence needs to be given that the caregivers' ideas are acted on to show they have been listened to: for example, keeping minutes from the caregiver-only meetings or demonstrated uptake of suggested actions. The caregivers were willing to take minutes of their caregiver-only meetings as evidence of what actions had been decided on for follow-up. In this way they ensured that those staff who could not attend meetings kept track of what had been achieved. The minutes were made available to all staff so there was the opportunity to show how being listened to had contributed to changes in the workplace. This increased the participants' confidence in continuing to contribute to change within the facility.

The participants could also describe how this experience by talking about how being listened to and having ideas acted on would be positive for the quality of residents' care.

> "There's no follow up outcome from those issues that are raised [in larger staff meetings], so this [the caregiver-only meetings] would actually focus solely on the care, you know, the residents and the caregivers. And if there's issues with things not being done, or, you know, stuff like that, that to just have the caregivers at the meeting I think it would be quite valuable." [Advisory group, meeting one]

The results illustrated in the model indicate that if these aspects can be created in the workplace environment ARC caregivers will feel engaged in their work. The implications of this for the wider ARC sector and for future research are explored in Chapter Six.

## 5.5 Reflection on PAR process and research outcome

An important part of the PAR methodology is to continually reflect and adjust the process as the work progresses (Baum et al., 2006). This adjustment to the process helps provide further understanding of the results and consequently the implications for the ARC sector. This element of the PAR process was evident in Step One of the research through the development of the action plan. The decisions on which actions to include in the plan were determined by regularly asking participants how accurately the plan in expressed their ideas. In addition to a check-in with participants at the beginning of each meeting this reflection was also done by constantly reviewing the way the meetings were conducted and regular informal discussions with facility manager and nurse manager.

In Step Three interviews were conducted to collect verbatim data on what changes the staff observed in the facility as a result of the PAR process and on how they had experienced the process itself. From both the caregivers' and management perspective the PAR was experienced as positive process.

> "And it [PAR] has given them [caregivers] a greater voice, if that's how you want to put it, you know, they're not afraid to speak out. They've given [a] forum for them to say what they want to say and not feel that they're saying the wrong thing. And I think they focus more on advocacy for the residents as well." [Advisory group, evaluation interview]

> "I know that we've had the home assistant's [caregivers] meeting set up, they've become a regular thing. I think that's the main thing that's come of it, actually. Meeting regularly, and discussing residents in depth. Just initiatives around better care, and you know, ideas that they may have for improvement." [Quality manager, evaluation interview]

The opportunity for reflection on the results and the model was at Step Four where all staff members were specifically invited to give feedback on the results of the data collected. Although no verbatim comments were recorded for this meeting, the feedback from the nurse manager after the meeting indicated that they all felt positive about the model that was developed and confirmed that it contributed to their understanding of staff dynamics in their workplace environment. They indicated that the caregiver-only meetings were continuing, and the RNs were supportive of these meetings as they saw that positive changes occurred as a result: for example, in the delivery of personal care to the residents. The participants in this

final meeting summed up the most positive outcome as being that the meetings enabled them to try out new ideas in their workplace, with an acknowledgment that learning opportunities had arisen regardless of whether or not a specific action had been successful.

An additional outcome was that the participants found that new ideas could be implemented more easily now that the caregiver-only meetings were in place. They confirmed that these meetings provided an opportunity to talk about new ideas and evaluate the amount of support for the ideas, and provided a forum for formal review with caregiver staff. The managers reflected that conflict within the team was managed more constructively across the facility workforce as a result of these meetings.

> "No one's saying it was a dumb question, or 'oh you're an idiot for asking,' or anything, they're very confidently raising issues and saying 'we think this is of concern, what do you think?' And chatting about it, which is good. I think that's always been there, but I think they're more comfortable with it now." [Quality manager, evaluation interview]

The managers also talked about the PAR study as part of an organisation culture change process and that it would take some time before new behaviours and ways of doing things were fully embedded, but that the whole team was keen to keep pursuing this.

> "For me the changes have been fairly subtle in a sense, you know, I'm noticing certainly a change in the way people relate and talk, and things like that, you know. There's definitely been some [change] and I think, you know, it's reflecting a change in overall staff culture (. . .) which is good."[Facility manager, evaluation interview]

While the feedback and reflections were mostly positive there was some constructive criticism of the process. The nurses in particular thought that the action plan should have been developed by more of the general staff and presented to the whole organisation, maybe more than once, to ensure good understanding and buy-in from all staff.

> "Yeah, it might of [sic] been a good idea, [to include more staff] because I've just got one thing that I have seen [which] is that the four people that are doing the study have come up with an action plan, but it hasn't always been what other caregivers have thought that needed to be actioned. That's one thing that I have noticed. But, yeah, it probably would of [sic] been a good idea to have a little bit more input, I guess, from the nurses." [EN/RN, evaluation interview]

They were aware that some staff did not feel they had been sufficiently included and did add some detailed ideas as to how to do this better in future research, for example, presenting the recruitment process at more than one staff meeting, presenting the action plan to several staff meetings, not just a couple of managers. Through exploration of the issue it became clear that they thought the outcome of this research was effective and offered this as a constructive suggestion. It could be suggested that their criticism was an expression of annoyance that the caregivers and not RNs were the focus of this research. However, they were mostly constructive in their comments and also talked about possible reasons why more staff did not take up the opportunity to be involved when it was first offered.

> "I don't know, it just— historically it's always been really hard to get people to meetings of any description. Yeah (. . .) I think it's good that they feel, the ones going, that they're getting heard. And that (. . .) you know it's benefitting them I think personally (. . .) which is nice." [EN/RN evaluation interview]

In the meeting in Step Four the staff described their interest in the research and the outcomes as they noticed as a result. The participants commented that some caregivers like to complain about their work environment but, despite being encouraged to go to the caregiver-only meeting, would not attend as it might mean they then had to take action or be accountable for their comments. The participants had some very practical suggestions such as changing the time of the meetings to being prior to the wider staff meeting, which might attract a few more attendees. They also suggested keeping the meeting to 30 minutes, although they agreed that this shorter time would mean the discussion would be limited, varying the day and time to attract more participants.

When the participants discussed the model they described it as a clear and useful way to better understand their experiences in the workplace. They had no additional suggestions to make and were generally positive about the accuracy of what it described and excited that they had been instrumental in its development. Their comments were thoughtful, insightful, and focused on how some change to the process could make any future PAR research more effective in encouraging caregiver engagement in their work in ARC. In the next chapter these results are summarised, linked to the research and the original research question, with commentary on what this research might mean for the New Zealand ARC sector.

# Chapter Six: Discussion

## 6.1 Introduction

This thesis has explored some strategies that encourage ARC caregivers to be motivated and engaged in a key work task: providing care for frail older people. A better understanding of these strategies should not only help encourage the engagement of these workers in their work but might also be useful in recruiting and retaining ARC caregivers. Literature on workplace engagement in the general population explains how worker engagement is related to meaningful business outcomes (Harter, Schmidt, & Hayes., 2002). This implies that if caregivers in this ARC workforce are engaged in their work they are more likely to provide consistently high standards of care for residents in ARC. Research into the motivation of this workforce can provide important insights into a workforce which is often low paid, unregulated, and has limited opportunities for education – and yet is responsible for the provision of intimate and personal care for some of the most frail members of the New Zealand community. The ageing population structure of New Zealand indicates an increasing number of older people in the future. It is likely that the proportion of older adults who live in ARC will remain the same, about 5% of those aged over 65 years. However, with increasing numbers in this age cohort the absolute number of frail older people in New Zealand who require this type of care will increase (Cornwall & Davey., 2004). This research has explored potentially low-cost strategies to improve the engagement of caregivers who provide this care. The cost of health care is rising as the complexity of health issues and the number of older people also rises (Blendon, Schoen, DesRoches, Osborn, & Zapert., 2003). The care delivered by the caregiver workforce will be provided in an environment of limited health funding; any low-cost intervention that supports staff retention and ensures that quality care is delivered by motivated staff will be of value to the health sector.

This thesis has described the wider health sector context relevant to ARC and the workplace environment of caregivers. A literature review synthesised selected literature to provide a context for the research and the results have been reported for two studies that were conducted in ARC facilities in Wairarapa – an initial exploratory study and a more in-depth PAR study. This final chapter will discuss the findings of the two research studies. These findings are linked to selected literature; the limitations of the research in this thesis are discussed; and

finally the implications of this thesis for future research and the wider aged care sector are identified.

## 6.2 Summary of key findings

The research for this thesis is in two parts – firstly a study was undertaken to explore the issues of engagement of caregivers which resulted in eight themes. The initial eight themes in this study were further refined to three core themes: (1) working with others, (2) having time to do the work, and (3) having pathways for professional development. These themes were used in the design of the second more detailed PAR study and resulted in a diagrammatic model that illustrated the workplace influencers and experiences that need to be in place for these caregivers to be engaged in their work.

### 6.2.1 Themes and action plan

The three themes that emerged from the analysis of the data collected in the initial study reflected the ideas that caregivers described as encouraging them to be engaged in their work. These were: (1) effective teamwork, (2) time to spend with residents, and (3) opportunities for professional development. While the initial exploratory study did not specifically use a detailed PAR approach, the process of facilitated focus groups did enable the voice of the caregivers to be heard through the process.

#### *6.2.1.1 Effective teamwork*

The first theme identified by participants described teamwork as most effective when enabled by positive relationships, specifically effective working relationships with other staff in an ARC facility. These could be between caregivers on the same shift, between caregivers on different shifts, or with other staff, for example, RNs or kitchen staff. The importance of relationships to encourage engagement has been highlighted in studies conducted with a registered nursing workforce (Callicutt et al., 2011; Warshawsky et al., 2012). These studies in the USA emphasised that effective relationships between nurses, between nurses and nurse managers/medical staff, or between nurses and administrative staff positively influenced their workplace engagement. However, little research has explored the impact of relationships relevant to the ARC caregiver workforce.

Working in teams is an essential aspect of the caregiver role in ARC as they are rostered on to shifts groups that cover a 24-hour period. These groups of staff are allocated a number of residents to care for during a shift. The participants in the initial study clearly identified that

robust, effective teamwork enables greater team member engagement in their work tasks. Despite that the participants were from four different ARC facilities in Wairarapa they all identified teamwork as of central importance. Not only did they recognise the importance of teamwork for caregivers but also the participants expanded the idea to include the wider staff team in ARC facilities. This wider view of teamwork in the healthcare sector has been identified as relevant to improved healthcare outcomes in research that explored the importance of effective relationships in multidisciplinary teams (Weller, Boyd, & Cumin., 2014). The importance of this to healthcare, and specifically caregivers, in ARC was evident when this theme was further developed in the PAR research project. The analysis of data from this second study resulted in the theme being more broadly defined as "Communication" and included in a model that provided a diagrammatic representation of how caregivers can be engaged in their work and their workplace.

#### *6.2.1.2 Time to spend with residents*

The second theme identified in the initial study described the importance of having enough time to do the work of caregiving and included both the time to perform the physical tasks of caregiving and the time to offer more emotional support by interacting with and caring about the resident as a person. The participants highlighted that having time to do the work increases the satisfaction that caregivers gain from their work. This is well supported in research that explored the efficacy of person-centred care models, which focus on the resident as the centre of the care delivery process. Improved job satisfaction and the implementation of person-centred models of care have been positively linked through research conducted in ARC, (Edvardsson et al., 2011; Wallin et al., 2012).

The frustration expressed by the caregivers at not having sufficient time to provide the care they would like to comes from a very personal understanding of the role of caregiver. The participants talked specifically about their passion for caring for older people and the importance of being able to make a difference in their lives. This indicates that there is an intrinsic motivator for ARC caregivers to be engaged in their work; that is, the personal satisfaction gained from caring for older people. This concept has been supported by research into motivational factors in jobs that are often low paid and low status. Intrinsic and extrinsic motivators were found to be important in predicting high levels of job satisfaction but only extrinsic factors influenced intent to leave a job (Morgan et al., 2013). An Australian study by Martin (2007) showed that while there are high turnover rates in these low-paid jobs intent to leave can be influenced by improving job satisfaction, which in turn is enabled by the

experience of caring. This theme describes the importance in job satisfaction of time to care for residents and is therefore relevant for developing strategies to address the high turnover rates in the ARC caregiver workforce.

The theme of "Time to care for residents" was further developed in the second research project and was included in the model developed from the data analysis; that is, "Contributing to the workplace". An example of how this was demonstrated in the PAR process was through the participants' identifying ways of allocating residents to staff on a shift that gave time to do all the cares required, physical, and emotional. This theme was also developed through the analysis of data in the second study to include not only time to care for residents but also time for more personal care. This reflected the importance of this intrinsic motivational factor and was included in the model as "Caring for oneself".

#### *6.2.1.3 Professional development*

The third theme in the initial study described the participants' view of the importance of professional development, which included both training opportunities and performance appraisals. While they agreed that training is an important aspect in enabling engagement in the workplace, they also described the barriers that made access to training difficult. The importance of training or education for this workforce has been demonstrated in a New Zealand study by Smith et al. (2005), which linked education of caregivers and improved levels of care.

Performance appraisals were regarded by the caregivers as important professional development opportunities. They are often used to identify areas for professional development support, most often provided in the form of training, which enables staff to develop relevant skills and knowledge. This form of constructive feedback is an important human resource tool and can encourage staff to care for themselves and consequently sustain the workforce (Kuvaas, 2006). However, the analysis of the data collected in the PAR research project did not reveal that professional development should be included in the diagrammatic model, although the relevance of the concept for participants was demonstrated when they included professional development in the action plan they developed (Table 5.4). The use of the PAR process in the second study indicated that there was a less formal opportunity for professional development of caregivers through the research process. The participants in the research process were not just following instructions and implementing tasks but were able to develop new ideas for improved delivery of care to residents, set up their own meetings, and run them. This created opportunities to develop new knowledge and skills.

#### *6.2.1.4 Action plan from the PAR study*

In the PAR study an advisory group of four caregivers actively participated in discussing the three themes from the first exploratory study. From these discussions they developed a set of actions they believed would encourage workplace engagement. These actions were formalised in an action plan that was presented to management for implementation. The content of the plan came from the caregivers with support from JP to produce the document. The extent of their participation and ownership of the process was demonstrated when they shared the draft action plan with a wider group of staff before it was formally presented to managers. The sharing of the draft plan with other staff was not originally part of the research design, proposed by JP, but this action by the advisory group of caregivers had the impact of increasing support from all staff for Step Two of the PAR process, which was to implement the actions.

The content of the action plan was not complex regarding the actions proposed it in, and in essence the actions in the plan are similar to those that could be expected as the outcome of any standard organisation development process. For example, the actions in the caregivers' plan included descriptions of improved methods of communication, ways to improve leadership, and relevant opportunities for workforce development. These types of initiatives underpin current human resource management strategies (Bratton & Gold., 2017). However, the action plan in this research was developed by a group of workers who are not always included in the development of these strategies in ARC facilities. By putting their proposed actions into a plan and working with management to get the actions implemented, they demonstrated they could make valuable contributions to their workplace and consequently the quality of care delivered by the facility.

### 6.2.2 The model – a diagrammatic representation of how caregivers can be engaged in their work and their workplace.

The key findings of this research are expressed as a model detailed in Chapter Five, which illustrated how three interlinking influencers and experiences can enable the engagement of caregivers. The three influencers that are shown in this model can be used to inform ways in which an ARC facility can provide a workplace environment that will encourage caregivers to be engaged in their work. The interconnectedness of the influencers underpins the model and creates experiences for caregivers that enable workplace engagement. The three influencers of "Communication", "Contributing to the workplace" and "Caring for oneself" need to be

present in the workplace to enable caregivers to be fully engaged. Where these influencers overlap the caregivers experienced their workplace in three ways “feeling valued”, “being listened to”, and “having a voice”. At the centre of the model is the engagement of the caregivers in their work.

The first influencer is described as supporting opportunities for caregivers to have effective interactions with staff, that is, “Communication”. Communication opportunities in the workplace were shown to support the development of effective relationships with a range of staff, which consequently encourages engagement as demonstrated by previous research that explored engagement and relationships in the nursing workforce (Warshawsky et al., 2012). The data in the PAR research highlighted a number of practical ways, both formal and informal, that communication can be used to build these important relationships, such as formal minuted meetings and informal resident handover meetings. As well as encouraging effective relationships these opportunities support quality care as information is passed on to staff about resident care; for example, medication changes and knowledge to be shared such as how to use new equipment. In summary, this influencer identifies the importance of having opportunities in the workplace for the caregivers to use communication to both build effective relationships and share information, which in turn encourages them to be engaged in their work.

The second influencer was described as “Contributing to the workplace”. Participation underpins this influencer by indicating that engagement is enabled when it is possible for caregivers to participate in the decision making processes in their workplace. In the PAR process used in this study the participants determined the actions they identified as enabling engagement. These were then presented to management as their contribution to improvement in their workplace. The caregivers in the study were involved in contributing ways to improve specific processes in their workplace such as workload allocation and identification of health and safety issues, for example, infection control concerns. They demonstrated that they were able to do this in the wider workplace when they identified not only issues relevant to their own work tasks, but also to tasks in other areas of the facility. For example, the main infection control issue they identified highlighted concerns with how the kitchen staff completed their tasks. Anecdotally this has not been a recognised role for caregivers and they can be undervalued in their contribution to the facility. This sense of not being valued was echoed by caregivers in this study who described themselves as having very little opportunity to contribute to workplace issues, as detailed in Chapter Five. This is difficult to substantiate as

there is little research into the workplace experience of ARC caregivers. However, it may be influenced by views that as they are not a health workforce that is regulated, as are the RNs, in their workplace consequently they are assumed not to have valuable opinions or ideas. In contrast to this, other regulated members of this workforce, such as RNs, are more often included in workplace decisions. The findings from this research indicate that including caregivers in workplace decision-making enables their engagement in their work and this in turn can have a positive impact on the functioning of the ARC facility.

The third influencer is described "Caring for oneself". Finding time in the daily work of an ARC caregiver is difficult. The role is task driven and there are often unexpected events, for example, if a resident has a fall the time allowed for an existing task such as dressing must be extended, potentially creating stress for the caregiver. This PAR research indicates that having time to "care for oneself" is important in enabling an engaged workforce. The importance of being able to care for oneself as a factor in building resilience and positive coping responses to manage the stressors of caring is supported by a US study by Pearlin, Mullan, Semple, and Skaff (1990). This qualitative study of 555 participants collected data from open-ended exploratory interviews over two years from people caring for someone living with dementia. The data was used to build a model describing primary stressors (i.e., the range and number of activities supported by the caregiver) and secondary stressors (i.e., the economic circumstance, the role, and the level of self-esteem of the caregiver). Although this research is not directly generalisable to the New Zealand ARC context, their claim that the factors that mediate the stressors (i.e., coping strategies and social supports) resonates with the finding in this thesis that caregivers need time to care for themselves (i.e., to build resilience and have effective relationships) in order to have the capacity to be engaged in their work. The model developed from data collected for this thesis proposes that the influencer of "Caring for oneself" enables caregivers to be engaged in their work.

Most of the previous research into how to manage the stress of caregiving described the experience of informal carer, that is, family. However, the coping strategies that are identified for these carers are relevant to more formal carers such as ARC caregivers. A clinical review paper by Adelman, Tmanova, Delgado, Dion, and Lachs (2014) aimed to summarise the epidemiology of stress experienced by informal caregivers. This research used the methodological approach of reviewing cohort studies and systematically reviewing carer burden interventions. From this data they described ways to support carers that are relevant for clinicians who work with families who provide care. The strategies they detailed in their

paper were (1) to become a member of the care team, (2) to improve self-care and physical heath (3) provide education and information (4) use technology, (5) refer on, and (6) use respite care. In the discussion of these strategies they mention the importance of asking for help, of getting support, and of being part of a wider team. While this review paper is not in the context of a workplace it does have relevance to the model developed in this PAR research, which also highlights the importance of caregivers in ARC caring for themselves to manage the stressors in their role and consequently to be engaged in their workplace. Providing a formal opportunity for the caregivers to be able to talk about the stressors they experience in their work, both emotional and physical, was identified by participants as important for enabling their workplace engagement. The participants identified that having a place to do this with their peers only was essential in ensuring their concerns were heard and acknowledged. Having a formal caregiver-only meeting was a practical way they proposed to address this.

The diagrammatic model describing how caregivers can be engaged in ARC service delivery was developed from the analysis of data obtained throughout the research process. It illustrates how caregivers can be engaged in their work and their workplace. Not only does this offer a way of expressing caregiver engagement in a visual model but it also indicates areas in which strategies could be developed to validate the model. Other models have been developed for more generalised workforces that help explain the engagement of workers in their workplace (Bakker, & Demerouti, 2008; Leiter, 2008). Although these models provide a diagrammatic understanding of engagement, they are not specific to both the personal and the workplace elements of the ARC caregivers' workforce. The model presented in the research for this thesis has been developed from data collected from caregivers themselves and consequently is specifically relevant to understanding the engagement of the New Zealand ARC caregiver workforce. The use of authentic participation, which underpins PAR methodology, to collect data ensured the relevance of the model to this workforce. It was validated when reflected back to participants at the facility. The model gives clarity to the understanding of what enables ARC caregiver motivation and consequently engagement in their work, which is the aim of this thesis and has helped understanding not only of the workplace engagement of caregivers but also why the research journey was reported by participants as being a positive one.

### 6.2.3 Reflection on the research process

The PAR design required a process that enabled the caregivers to be included in the research activities as active participants rather than just as people whom researchers collected data about (Baum et al., 2006). This process was an effective way to gather data to develop a descriptive model to increase understanding of the workplace experience of these workers and inform professional practice. While this is a positive outcome, it is worth reflecting on an aspect of the research process that supported this – the "fit". This discussion on the research process covers both the fit of the researcher and the PAR methodology, and also the fit of the ARC sector and the PAR methodology.

PAR is a dynamic process and can take the research in different directions: not always ones that are anticipated. A study by Snoeren et al. (2012), which explored the relationship between researcher and participants in a PAR process indicated that the quality of the relationships was important for the successful outcome of the research. This study in a care facility, which was collaboration between nursing schools and health providers in The Netherlands, used the PAR methodology to assist in the development of the workplace and improvement in the quality of care. The authors of the study concluded that there must be a good fit between the researcher and the methodology for the process to be effective. The researcher needs to be able to manage ambiguous situations and trust that participants will contribute useful data that will address the aim of the research. In the study reported in this thesis a strong element of trust was required that the participants would lead the research in a direction that supported the research aim. This required JP to accommodate delays and changes in the original design that impacted this process. This high level of trust with both participants and management and being able to keep the process relevant to the research aim was enabled by the experience and knowledge JP had of the ARC sector – making this a good fit between researcher and methodology. PAR is not a linear process and a degree of tolerance of ambiguity was required when the process appeared to be going off track, and an ability to bring the focus back to the research aim while at the same time ensuring that the voice of the caregivers was heard and not dismissed. It was important to consider the fit of research aim, methodology, and researcher to ensure the relevance of the findings.

To provide a context for the choice of methodology, a selection of literature was reviewed to explore action research and its use in the ARC sector, which was detailed in Chapter Four. A study by Lindeman et al., (2003) confirmed that PAR is a valid methodology for use in exploring ARC caregivers' experience of work. This Australian research project (Well for

Life) was conducted with five ARC facilities. The first phase of the study, which focused on nutrition, demonstrated that action research enabled the inclusion of staff in identifying issues and actions that positively influenced professional practice in these ARC settings. The research for this thesis used PAR to support caregivers to have a voice and ultimately develop a model that not only increased understanding of their workplace, but could be used to influence professional practice. This showed that for this group of health care workers this methodology was a good fit and provided effective outcomes. The detailed data collected in the study indicated the participants had a high level of communication skills, which is especially important when asking them to identify issues and actions explained as being essential Lindeman et al.'s (2003) study. The data collected in the research for this thesis gave some indication that caregivers could identify issues, offer contributions, disagree with each other, and offer solutions, which indicated a high level of communication skills in this workforce. However, although a high level of communication skill was evident in the participants in this research it is pertinent to note that if this was not present the process may not have been as effective. If there had been more participants in the advisory group, which was small ($N$ = 4), or they had been less willing to participate in the discussion the process could have been less effective in obtaining the detailed data.

When reflecting on the research process it is relevant to consider the power dynamics that are likely to influence the process. As an outsider working with the participants JP arguably had more power. The recruitment process was voluntary and informed consents were obtained but there is no doubt that a researcher with experience ARC management would have more power in the research relationship than a caregiver. This power imbalance was acknowledged in the data collection process by continual reflection back to the participants of their comments and checking that what was reported in the action plan was what they intended to say. However it should be acknowledged that this power differential cannot be entirely eliminated and would have had some impact on the outcome of the research.

## 6.3 Relevance to selected literature

The three themes that emerged from the analysis of the data collected in the initial exploratory study (the importance of teamwork; having time to spend with residents; and opportunities for professional development), share a commonality with themes that have been identified in studies in other workplace contexts. The first theme, importance of effective teamwork in enabling workplace engagement, was demonstrated in a study with US nurses in cardiology

by Callicutt et al. (2011). This study measured the level of engagement of nurses ($N$ = 82) and found that one of the tenets they used for this measurement that improved engagement was "Creating a sense of team" (p. 83). They argued that when the leadership team actively created a sense of team for the staff this experience encouraged a more engaged nursing workforce. This was also identified as a positive influence on workplace engagement by caregivers in the research for this thesis.

The second theme "time to spend with residents" is reflected in the concept of person-centred care, which focuses on how responsive care is to the needs of the residents. Person-centred care levels are likely to be higher if time is allowed for the carer to spend with residents and consequently they have an opportunity to fully understand and deliver care that meets the residents' needs. Person-centred care has been linked in research to workforce engagement. The positive impact of this approach on the workforce is illustrated in a US study by Tellis-Nayak (2007). Their study used staff and family satisfaction studies to show that managers who developed a person-centred care approach in their facility added value to the caregivers' workplace. The staff in the study in a specific healthcare setting, who experienced their workplace as delivering a high level of person-centred care, reported higher levels of job satisfaction as measured in the questionnaires. The authors report many statistical tests for association and only report correlation coefficients between satisfaction with various work-related experiences where a $p$ value was $<0.01$. In the main results table in this study these associations are ranked by the magnitude of the correlation coefficients. While there are limitations in the use of self-reported satisfaction surveys, results support the theme expressed by participants in the current study in this thesis as "time to spend with residents" as a factor encouraging workplace engagement of caregivers.

A more recent Swedish study by Wallin et al. (2012) also found that implementing a person-centred care model positively influenced the level of job satisfaction experienced by ARC workers. This study used questionnaires to measure the satisfaction levels amongst nurse assistants ($N$ = 225) in dementia-specific residential care services. In a statistical model predicting overall job satisfaction, feeling physically exhausted and feeling worried and restless were negatively associated with job satisfaction; and personalised care provision and a caring climate were linked to job satisfaction. Although the researchers report a good response rate this was in fact only 69%, so non-response bias may influence the strength of these associations. For example, those who are less motivated to respond to questionnaires may also be less motivated at work. However, the results suggest that workplace engagement

is positively influence by person-centred care, which in turn emphasises the importance of time spent with residents.

The third theme of "professional development" did not become an influencer in the model developed from data collected in the second PAR study. An explanation could be that this theme describes an extrinsically motivating factor and these factors have been found to influence intent to stay rather than workplace engagement (Morgan et al., 2013). This study used a mixed-method approach of survey and interview/focus groups to collect data, in which they demonstrated that intrinsic factors significantly influenced job satisfaction. Extrinsic factors primarily influenced intent to stay in their sample of US frontline healthcare workers ($N$ =1006).

In summary, the themes that emerged from the first study in this thesis are somewhat similar to themes found in literature: but importantly these themes were described by caregivers themselves without apparent intrusion or prompting from management, residents, or their families. This indicated that understanding the themes that describe what motivates and engages this specific workforce may be achieved by simply asking the relevant staff.

The diagrammatic model derived from the collection of data in the second PAR study for this thesis described the environment that enables caregivers to be engaged in their work and included the importance of "Communication", "Contributing to workplace", and "Caring for self". These influencers can be described as intrinsically motivating factors because they are not contingent on formal external reinforcement, for example, by pay or legislation; but arise within a person. This was originally detailed in work by Herzberg et al. (1959) in their two–factor theory, exploring the factors of intrinsic and extrinsic motivation, and is used to explain why human beings engage in tasks. The impact of intrinsic factors for front-line health care workers reported by Morgan et al. (2013) was found to be significant in influencing job satisfaction. The findings of the empirical research conducted for this thesis also suggested that these intrinsic factors described by the caregivers enabled them to be engaged in their workplace and therefore to have improved job satisfaction. The complexity of understanding factors influencing job satisfaction and engagement is illustrated in research by Coomber & Barribal. (2007). They concluded that addressing job satisfaction of the health workforce also assists in managing retention and turnover issues. This implies that while the research for this thesis advances understanding of strategies to address job satisfaction for caregivers in ARC, the findings could also provide some insight into strategies to address the important issues of managing the retention and turnover of this essential workforce.

"Communication" is described as an influencer in this model. This thesis did not explore the topic of communication in the selected literature as it is an extensive area of research in its own right. Communication in the model outlined in this thesis specifically describes communication between caregivers; that is, on the same shift, between shifts, or with RNs. Communication between caregivers is described in this thesis as teamwork and has also been found to support engagement in research by Callicut and colleagues (2011) in their study into engagement of cardiology nurses in the US. A study by Tellis-Nayak (2007) of nurse assistants in US nursing facilities ($N$ = 234) found that managers who demonstrate their ability to listen and to show they care, that is, communicate with caregivers, enabled engagement and developed a workforce who cared about their work. The research in this thesis shows that RNs are in a management and leadership relationship with ARC caregivers on a daily basis. The model proposes that effective communication between these staff in the New Zealand ARC context is important in enabling engagement, which was also found by Tellis-Nayak (2007), albeit in a sample of US nurse assistants. The importance of this critical relationship in the caregiver's workplace is also shown in Australian research by Etherton-Beer, Venturato, & Horner (2013)into the organisational culture of residential aged care facilities. This research used a cross-sectional observation study of 21 aged care facilities across Queensland and Western Australia. The participants were staff and next of kin ($N$ = 3392) in the selected facilities. They reported that leadership was relevant to all aspects of culture including staff retention. The research for this thesis found a similar relevance; for example, initial leadership was shown by the facility manager who agreed to participate in the research and this continued throughout the process with leadership from other managers in the facility. Also, the action plan specifically mentioned ways to develop RN leadership, which was identified by caregivers as vital for effective communication and "feeling listened to" and therefore enabling them to be engaged in their work. These findings show that caregivers can identify those aspects that enable them to be engaged in their workplace by actively participating and being included in the workplace. Supporting this participation by leadership at multiple levels will ensure the development of an environment that enables workplace engagement.

"Contributing to the workplace" indicates that caregivers benefit from being able to contribute ideas as to how their workplace is organised. The organisation of work in ARC is an important aspect of developing a person-centred care approach to care delivery. Caregivers are often able to describe their workplace and the needs of residents with detailed accuracy as

they are the staff who spend the most time with residents and provide intimate physical care and emotional support to them. The person-centred care approach was found to have a positive influence on job satisfaction for aged care staff in a study conducted by Edvardsson, et al., (2011). This Australian study of ARC staff ($N$ = 297) used two assessment questionnaires, firstly the Person-Centered Care Assessment tool by Edvardsson et al., (2010) and secondly the Measure of Job Satisfaction, to assess provision of person-centred care, and a third was used to assess job satisfaction. These data showed that person-centred care was significantly associated with job satisfaction for this sample of caregivers. An aspect of ARC service delivery where caregivers contribute to the decision making in the workplace is in the implementation of person-centred care. As caregivers know the resident best, they are the staff members most likely to able to make decisions that ensure the residents' care is focused on their needs. The findings from this thesis describe this as "Contributing to the workplace". This thesis suggests as do the findings in the literature, that by providing opportunities that give caregivers the sense of "Contributing to the Workplace", for example through the development of person-centred care, these caregivers will experience improved job satisfaction and workplace engagement.

As noted in Chapter Five "Caring for oneself" was an unexpected result of the analysis. However, there is research to support the relevance of this to the improved job satisfaction of caregivers. Research by Wallin et al. (2012) found that the existence of a caring climate and providing personalised care positively influenced job satisfaction for nurse assistants in Sweden and it could be argued that a caring climate will be created when staff are also given opportunities to care for themselves. The importance of being able to care for oneself as a factor in building resilience and positive coping responses to manage the stressors of caring is supported by a US study by Pearlin et al. (1990). Data was collected from caregivers and used to build a model describing primary stressors (i.e. the range and number of activities supported by the caregiver) and secondary stressors (i.e., the economic circumstance, the role and the level of self-esteem of the caregiver) for their specific sample of caregivers of people living with dementia. Although not directly generalisable, their findings support the model developed from data collected for this thesis, which proposes that the influencer of "Caring for oneself" enables caregivers to be engaged in their work – which in turn is a reflection of job satisfaction.

This thesis also considered research that focused on the New Zealand ARC caregiver workforce. Comprehensive demographic studies have been conducted by Kiata et al. (2005),

Jorgensen et al., (2009) and Badkar et al., (2009). These studies provided a wide-ranging picture of the workforce and highlighted critical issues such as retention and turnover in the New Zealand context. This detailed demographic data has been updated by Ravenswood and colleagues (2016), giving current insight into the complexity of the workforce. Some of the research into the New Zealand ARC caregiver workforce has also explored issues relevant to the ethnic mix of the workforce. Ngocha-Chaderopa and Boon (2016) explored managing the increasing diversity of ethnicity in the New Zealand ARC caregiver workforce in a study conducted with managers in ARC facilities in Dunedin ($N$ = 28). This study illustrated three themes that need to be addressed – (1) communication and language barriers, (2) racism by manager, residents, and families, and (3) underemployment of tertiary qualified migrants. Some studies into the ARC caregiver workforce have explored specific issues related to their work; for example, Smith et al. (2005) explored the impact of education on caregivers ($N$ = 15) in one residential care facility in Auckland. They did a pre- and post-evaluation study using a 10-session education programme to demonstrate positive impact on the quality of care delivered by ARC caregivers. However, while issues for workforce retention and skill mix are identified in their research, none of these studies have specifically explored the workplace experience of ARC caregivers and the environment that encourages them to be motivated and engaged in their work, as found in the studies in this thesis.

In summary, the themes and model developed from data collected for this thesis are supported by selected literature from an international and wider health workforce perspective. However, the context of the studies makes it difficult to generalise the findings to the New Zealand ARC caregiver context and there is little research that explores ARC caregivers' specific workplace experience. This suggests a gap in the literature that is relevant to the specific aim of this research, which is to develop a better understanding of the factors that encourage New Zealand ARC caregivers to be motivated and engaged in their work.

## 6.4 Limitations of the research

The PAR process requires a cyclical approach with the Plan, Act, Observe, Reflect cycle being implemented to collect data and then to determine the actions that should follow (Baum et al., 2006). The process and analysis was continually reviewed with thesis supervisors, staff at the facility and with reference to the researcher's experience in ARC to validate the results. Throughout this process the data were interpreted as part the analytical process. This could be seen as a limitation as it was a subjective process. There is no doubt that the presence of the

researcher in the process influenced the findings and conclusions. In fact, this is explicitly the intent of PAR methodology, with this influence being regarded as adding value to the depth of understanding of the research question. The use of inductive logic to explore research questions is a recognised and useful approach to qualitative research in public health (Baum et al., 2006). While acknowledging the potential limitation in the interpretative nature of this research methodology, in terms of the rigour of the results, this is also an opportunity for creativity and flexibility in the research design. This methodology is useful in designing research into important health issues and especially in gaining insight into the perspective of disadvantaged groups. As argued by Thorne, Kirkham, and O'Flynn-Magee (2004) this interpretive approach delivers "constructed truths" rather than "facts" (p. 6).

A second limitation is that participants in this thesis were recruited from one rural, community-owned ARC facility. This is not representative of all models of facility ownership in the sector in New Zealand. As described in the background given in Chapter One ARC in New Zealand is delivered by a mixture of private providers who run their facilities as businesses for profit and other providers who have a model of not-for-profit ownership. Facilities also differ in terms of the wealth and ethnicity of residents. The New Zealand public health system no longer provides long-term care facilities for older people. The not-for-profit and charitable providers are a mix of private individuals, religious/welfare organisations, and community-owned facilities. The facility in this study is one of the latter. The results may have been different if the PAR research was conducted in an urban and/or corporately owned facility as these facilities may be less likely to have strong community ownership. The size of these facilities may limit the degree to which they are able to be responsive to a research project that requires a researcher to be present on site in a potentially invasive way. For instance, the workforce in urban facilities may be more mobile as potentially there are more employment opportunities. The movement of staff to other employers could limit the reliability of data collected as there could be less stability in the participant group. The workforce in an urban facility may be more ethnically diverse as a larger urban population would give a larger pool of potential employees. In addition, it is important to note that this research is specific to New Zealand healthcare sector and would be limited in its potential for generalisability to the international healthcare community. Furthermore, ARC facilities differ in terms of size. The ARC facilities involved in this study were relatively small in comparison to some urban facilities. There is a question about how easily the methods from this study and the results arising from it could translate to larger institutions.

As noted the ethnicity of the sample group may be a limitation. Not only was the sample in the PAR study from a rural town with a small population and 84% of the 6000 residents were New Zealand born (New Zealand Census data, 2013) but also the participants in the sample were not representative of the ethnic mix of the ARC caregiver workforce; they were predominantly New Zealand European with English as a first language. In a recent demographic study using survey methodology Ravenswood et al. (2015) found that 42.7% of the caregiver respondents ($N$ = 266) were from Asian countries and could be assumed to have English as a second language. In the current research none of the participants identified as Asian and all had English as a first language. These participant characteristics will have influenced the data collected and consequently the findings arising from the analysis. All the participants had relatively high levels of communication skills demonstrated by their fluency in the use of English language. They could all actively participate in group discussions, which was essential to the collection of data. If a different sample of caregivers in future research were not as effective in their communication skills the data collection could be limited, consequently affecting the results.

While the approach in both studies enabled the voice of the caregiver to be heard the sample size was small. In the first study there were only four focus groups with nine participants and the second study, while larger, had only 50 staff in the facility, not all of whom participated in the study. In specific feedback on the PAR process the participants themselves highlighted the small number of staff involved in the development and review of the action plan as a limitation. Only three actions were implemented and while these were determined to be the most important by the participants, there is no doubt that it is questionable whether they are sustainable in future. There was a verbal commitment from the nurse manger to continuing the actions and implementing others but if this does not occur this may also limit the sustainability of the results.

Finally, the facility chosen for the PAR study had attained four years certification from the Ministry of Health, indicating it was already delivering a high standard of care. Different results may have been produced in a facility not as well managed or already proven to deliver a high standard of care.

## 6.5 Implications for the ARC sector in New Zealand

The ARC sector, as in the wider health sector, is constantly challenged to provide quality health care with limited funds. The PAR process used in this research shows that this

methodology could be used to help meet this challenge. The authentic participation of caregivers in this research resulted in improved understanding of how they could be more engaged in their work and consequently in the delivery of a quality standard of care for residents. Although some specific actions were implemented in the facility that participated in this research it is the generalisation of the research methodology that is focus of this discussion. Four elements can be identified from this research that support the PAR process, (1) management support, (2) skilled and experienced facilitation, which can build trust with staff, (3) inclusion of all staff, and (4) constant feedback to staff. These elements are available to any ARC facility at relatively little cost.

Firstly, support from management is essential in any process that takes staff away from their usual work tasks and requires decisions to be made about the implementation of actions that are outside the existing service delivery model. If a facility wants to start a process of PAR commitment from all managers is required to support the process to its conclusion. Secondly, authentic participation of staff requires them to take some risks in the issues they raise and the confidence they have to make suggestions. An external facilitator can give a sense of some impartiality to support staff to have the confidence to fully participate. However, this role also needs to understand the sector to develop credibility and to provide a check on the practicality of suggestions and potential changes. If expectations occur as staff become enthusiastic about the opportunity they have to contribute to the workplace and these go unchecked, then unrealistic expectations can be set and the positive relationship with staff could be undermined.

A third element recognises the importance of the inclusion of participants, which is essential in PAR reach methodology, as noted by Snoeren et al. (2012) who highlighted the impact on the quality of the research outcomes if all participants are not engaged or included. If a facility embarks on a PAR process to assist in quality improvement it must include all staff at key stages. The use of a small advisory group can help keep the process focused, but unless their work is shared with all staff there is a risk that some staff are excluded, which could limit the success of the process. The inclusion of all staff can be achieved through a number of communication techniques specific to the facility, but these techniques need to be identified at an early stage to ensure that this inclusion occurs.

Finally, the process outcomes must be included in regular feedback to all staff. This concept of constant feedback and adjustment of the process underpins the PAR cyclical methodology as reiterated by Dickens and Watkins (1999) and also evident in the four elements identified

earlier in this discussion, which are specifically relevant for the ARC sector. Constant feedback to staff will ensure that management support is always visible, that the facilitator is not overtly influencing the outcomes, and that all staff are included.

There are many differences in ARC facilities in New Zealand. The use of a PAR process to support a quality improvement process would need to take account of these differences, such as number of beds, staff mix, levels of care, and urban/rural environment. However, these differences are all manageable within the process through identifying specific strategies to address them in the initial stages of the process. Using the four elements discussed above with recognition of the differences in individual facilities could assist in achieving positive changes in the wider ARC sector New Zealand. More specifically the results of this research give clear guidance for any ARC facility on how to create an engaged and motivated workforce and therefore to provide improved levels of care to residents. It is indicated in Chapter One of this thesis there will be increasing numbers of frail elderly people requiring this type of care and there is an obligation to ensure this care is of the highest standard possible. This research gives a useful model, and practical strategies, for ensuring this is achievable through an engaged and motivated ARC caregiver workforce.

## 6.6 Future research

As described in previous chapters, the ARC sector in New Zealand is complex and will be under increasing pressure to meet the demand for services with a shrinking supply of workers from all disciplines, including caregivers. This research has increased the understanding of the workplace environment that enables caregiver engagement. Not only has a model been developed from the data that describes how caregiver engagement can be enabled, but this research also provides some practical strategies to be used in ARC facilities to help address staff retention and the quality of care delivered. The supply of the workforce in ARC will be a continuing issue for the health sector in New Zealand. As an occupational group RNs in aged care are now on the intermediate skills shortage list (Ministry of Business, Innovation and Employment, 2016) and are described as workforces who are required in New Zealand immediately as no New Zealand citizens or residents are able to take up these roles. In addition the recent employment settlement by DHBs (New Zealand Nurses Organisation, 2018) for the RNs has resulted in a pay gap between the DHB nursing workforce and the ARC workforce, which may well see a drift of this workforce to the DHB sector. The impact of this on caregivers will mean fewer RNs to provide leadership, which they identified as supporting them to feel valued and be listened to. It may also lead to caregivers delivering

more complex care as the number of RNs in the sector decreases. This research adds to the understanding of the workplace experience of caregivers, which could assist in mitigating some of the impact of a decreasing RN workforce in ARC. It is complementary to the existing demographic research and provides more information about this workforce, who can feel unappreciated but who are essential in providing personal care to frail elderly people.

The limitations described in the previous section suggest that sample size, and a demonstrated high quality care in the facility studied may have influenced the results. To address this further research is needed using a similar methodological approach conducted in larger urban facilities. This way the robustness of the model would be tested with a more ethnically diverse and transient group of caregivers. Also, a similar research process could be undertaken in facilities that do not already have a well-established high level of care as with the facility in this research. The level of commitment from other facilities to both quality improvement and to implementing organisational change may be different to that of the one in this study, which could also test the robustness of the model and may result in a different outcome.

There is opportunity to explore the usefulness of the model described in this thesis by conducting this research process in facilities offering different levels of care. In particular, future research could focus on secure dementia care facilities to explore whether working with these residents, which requires additional skills, would identify different influencers to support a workplace environment that enables caregiver engagement. Caregivers working with residents with a diagnosis of dementia have a different set of skills and knowledge, less focused on the practical tasks and requiring more flexibility in the way they deliver care to this very vulnerable group of residents. Research conducted with these caregivers may identify different actions that enable workplace engagement. To conduct research in different settings would not only validate the model but also make it more generalisable to the wider ARC sector and consequently be of value to any ARC facility.

In a wider context a similar research design to that in the PAR study for this thesis could be utilised to explore the engagement of other workers who care for vulnerable people in settings other than ARC. This could be in group care homes for those with intellectual and psychiatric-related disability, and home support services. Careerforce, the Industry Training Organisation for this workforce, describes these workers as kaiāwhina, meaning part of the unregulated workforce (Careerforce New Zealand, 2018). Increasing understanding about how this wider group of workers can be enabled to be engaged in their work could have

impact on the retention of a vital workforce and the quality of the care they deliver; for example, community support workers. As the demand for healthcare services potentially outstrips the supply of healthcare workers (Badkar et al., 2009) this will be an increasingly important area for research findings to provide a deeper understanding and a range of strategies to manage the issue.

## 6.7 Conclusion

In conclusion, the aim of this research was to develop a better understanding of the factors that encourage caregivers to be motivated and engaged in their work and to develop and test methods for better caregiver workplace engagement in an ARC facility. The results from the initial exploratory study showed that the use of PAR methodology would more satisfactorily answer the research question. Consequently, the results from the second PAR study provided a diagrammatic way to understand caregiver engagement and some practical options for facilities to encourage workplace engagement. In addition, this research has demonstrated that the use of PAR methods for much-needed research into this sector can add value by creating positive change in ARC facilities. While many of us will get to an older age, not all of us will require residential care. However, if we do require this long-term care it is essential that this very personal healthcare service is delivered with the skill and compassion of motivated caregivers. Reports continue of very inadequate care in the sector, which suggests we have more to do to ensure quality care is consistently delivered by an engaged caregiver workforce to older people in residential care. A final quote from one of the caregivers in the study illustrates that there is skill and compassion in the ARC sector. While acknowledging that this caring commitment does exist in much of the caregiver workforce, the research for this thesis has endeavoured to enhance our understanding of how to ensure this important facet of ARC service delivery is more consistent in practice.

> “Like it's their home. You just remember that it's their home, and you're a visitor in their home, and so you don't prance around thinking you own the place, remembering to knock on the door, and (. . .) stuff like that, [remembering] their independence, their privacy.” (Caregiver)

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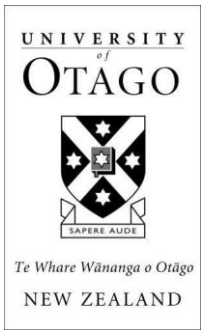
## Appendix 1: Participant Information Sheet




***WORKPLACE ENGAGEMENT OF HEALTH CARE ASSISTANTS IN RESIDENTIAL AGED CARE***

**INFORMATION SHEET FOR PARTICIPANTS**

Thank you for showing an interest in this project. Please read this information sheet carefully before deciding whether or not to participate. If you decide to participate we thank you. If you decide not to take part there will be no disadvantage to you and we thank you for considering our request.

**What is the Aim of the Project?**

To run a focus group with health care assistants in aged residential care to obtain data on how they perceive factors that are important for them in their work. The data will be collected through discussion guided by a workplace engagement survey of twelve questions (Gallup Q12).

This will enable better understanding of the motivation that these staff have to provide quality services to frail elderly residents in long term care.

This project is part of the requirements for Jenny Prentice's PhD research

**What Types of Participants are being sought?**

The participants will be health care assistants in aged residential care facilities in the Wairarapa DHB. They will be invited to attend by the facility manager and a mix of age, gender, ethnicity and length of service of participants will be considered in the attendees.

The focus groups will be held at a facility site, in a meeting room without the manager present, to make it easy for staff to participate. The focus groups will be held early afternoon

to enable most staff to attend before or after a morning or afternoon shift and/or from night shift.

The participants will not be personally identified but general demographic information for example, the number of men or women and the range of years worked in the role will be collected.

**What will Participants be asked to do?**

Should you agree to take part in this project, you will be asked to participate in a focus group that will take 90 minutes. During this time the Gallup Q12 questions will be asked and the discussion will be recorded on audio tape which will then be transcribed and analysed.

The process will be as a voluntary discussion with no-one being required to contribute. The maximum number of participants will be approximately 18 in three groups of 6.

Please be aware that you may decide not to take part in the project before the start of the focus group without any disadvantage to yourself.

**What Data or Information will be collected and what use will be made of it?**

The discussion that is generated by the questions will be recorded on audio tape. No-one will be identified and the data will be transcribed by an independent person. The written transcript will be used for the data analysis. The researcher and supervisors will have access to the transcribed data but the tapes will be destroyed as noted in the following paragraph. Any health and safety issues raised as part of the discussion will be reported to the Facility Manager.

The data collected will be securely stored in such a way that only those mentioned below will be able to gain access to it. Data obtained as a result of the research will be retained for at least 5 years in secure storage. Any personal information held on the participants may be destroyed at the completion of the research even though the data derived from the research will, in most cases, be kept for much longer or possibly indefinitely.

The results of the project may be published and will be available in the University of Otago Library (Dunedin, New Zealand) but every attempt will be made to preserve your anonymity.

Participants and facility managers will be able to see the final written analysis should they wish to but there will be no identifying data in this paper.

**Can Participants change their mind and withdraw from the project?**

You may withdraw from participation in the project at any time prior to the start of the focus group and without any disadvantage to yourself.

**What if Participants have any Questions?**

If you have any questions about our project, either now or in the future, please feel free to contact either:- Jenny Prentice, phone 021557205, email jprentice@clear.net.nz or William Levack, phone (04) 385591 ext 6279, email william.levack@otago.ac.nz

This study has been approved by the Department stated above. However, if you have any concerns about the ethical conduct of the research you may contact the University of Otago Human Ethics Committee through the Human Ethics Committee Administrator (ph 03 479-8256). Any issues you raise will be treated in confidence and investigated and you will be informed of the outcome

# Appendix 2: Departmental Ethics Approval

Form Updated: May 2014

## UNIVERSITY OF OTAGO HUMAN ETHICS COMMITTEE APPLICATION FORM: CATEGORY B

### (Departmental Approval)

*Please ensure you are using the latest application form available from: http://www.otago.ac.nz/council/committees/committees/HumanEthicsCommittees.html*

**1. University of Otago staff member responsible for project:**

William Levack, Associate Dean

**2. Department/School:**

Department of Medicine

**3. Contact details of staff member responsible:**

Dr William Levack PhD

Associate Dean - Research & Postgraduate Studies; Senior Lecturer in Rehabilitation University of Otago (Wellington), PO Box 7343, Mein St, Newtown, Wellington 6242, New Zealand

Email: william.levack@otago.ac.nz

Phone: +64 4 385 5591 ext 6279

Fax: +64 4 389 5427

**4. Title of project:**

Exploring the perception of factors that influence workplace engagement of health care assistants in aged residential care

5. **Indicate type of project and names of other investigators and students:**

| | | | |
|---|---|---|---|
| **Staff Research** | X | **Names** | Mark Weatherall |
| **Staff Research** | X | **Names** | Rebecca Grainger |
| **Student Research** | X | **Names** | Jenny Prentice |
| Level of Study (e.g. PhD, Masters, Hons) | | | PhD |
| **External Research/ Collaboration** | | **Names** | |
| *Institute/Company* | | | |

6. **When will recruitment and data collection commence?**

Early May 2015

**When will data collection be completed?**

Early August 2015

7. **Brief description <u>in lay terms</u> of the aim of the project, and outline of the research questions that will be answered** (approx. 200 words)**:**

Currently the members of the aged residential care workforce are predominantly health care assistants. This work force is characterised by being "unregulated", mostly female, from lower socioeconomic groups, and they are paid just over the minimum wage. They provide personal care for older adults living in aged residential care facilities who are frail and often totally dependent on the services of a health care assistant.

Work place engagement has been shown to have impact on the delivery of services and the retention and recruitment of staff. It is suggested that if employees experience well-being in the workplace, i.e. are engaged in the workplace then business outcomes e.g. turnover, customer loyalty, productivity and profitability will be positively impacted. This is important to enable a quality service to be delivered to these most vulnerable members of our community.

The aim of this study is to explore the perspectives and experiences of health care assistants in aged residential facilities regarding factors that influence their workplace engagement.

**8. Brief description of the method.**

The participants will be health care assistants in residential aged care facilities located in the Wairarapa DHB.

They will be invited to participate by the facility manager and consideration given to consider a mix of age, gender, ethnicity and length of service when of participants. They will not be personally identified but general demographic data will be recorded and they will given information about the project and consent forms.

A focus group process of 90 minutes duration will be used to collect the data. During which the Gallup Q12 questions which measure engagement of a workforce (see protocol for details) will be asked. These will be followed up with questions for clarification and the discussion captured by audio recorder which will then be transcribed and analysed.

The maximum number of participants will be purposeful samples of approximately 18 in three groups of 6, from three different facilities. The numbers are small to get more detailed data, enable all participants to contribute and to work with the shift requirements of the facility. The focus groups will be held at a facility site as the facilities that are willing to participate are in different towns. Many of these staff work close to home to reduce travel costs so traveling to another venue is not ideal. They will be held in a meeting room without the manager present. The timing of the focus group will be held early afternoon to enable most staff to attend before or after a morning or afternoon shift and/or from night shift.

(See attached protocol for details)

**9. Disclose and discuss any potential problems**:

Any issues that arise that indicate potential for serious harm to health and safety of residents or staff will be raised with participants and reported to the manager.

***Applicant's Signature:** .....

***Name (please print):*** ..... William Couch .....

**Date:** ..... 20/9/15 .....

*The signatory should be the staff member detailed at Question 1.*

*ACTION TAKEN*

☐ Approved by HOD ☐ Approved by Departmental Ethics Committee

☐ Referred to UO Human Ethics Committee

**Signature of **Head of Department:** .....

***Name of HOD (please print):*** .....Professor Sunny Collings
Dean and Head of Campus
University of Otago Wellington.....

***Date:*** .....28.APR.2015.....

**Where the Head of Department is also the Applicant, then an appropriate senior staff member must sign on behalf of the Department or School.

**Departmental approval:** *I have read this application and believe it to be valid research and ethically sound. I approve the research design. The research proposed in this application is compatible with the University of Otago policies and I give my approval and consent for the application to be forwarded to the University of Otago Human Ethics Committee (to be reported to the next meeting).*

**IMPORTANT NOTE**: As soon as this proposal has been considered and approved at departmental level, the completed form, together with copies of any Information Sheet, Consent Form, recruitment advertisement for participants, and survey or questionnaire should be forwarded to the Manager, Academic Committees or the Academic Committees Administrator, Academic Committees, Rooms G22, G23 or G24, Ground Floor, Clocktower Building, or scanned and emailed to either gary.witte@otago.ac.nz. or jane.hinkley@otago.ac.nz

## Appendix 3: Research Approval Letter from Carter Court Society


Carter Society Inc.

Trading as Carter Court Residential Home,

95-97 Pembroke Street
Carterton 5713 New Zealand
Telephone: (06) 379 8076
Fax: (06) 379 5113
Email: manager@cartercourt.co.nz
Website: www.cartercourt.co.nz


Date: 21.06.16

To Whom It May Concern,

**Ref: Research Proposal by Jenny Prentice**

***"Using participant action research methodology, explore how teamwork on a shift can enhance workplace engagement of health care assistants in aged residential care".***

The Carter Society owned Carter Court Rest Home was approached and has agreed to participate in the proposed research by Jenny Prentice.

Our interest lies in the following:

- The focus on building effective teams and improving team work for care
- The emphasis on Home Assistants – an undervalued but vital section of the aged care workforce
- From the research our ability to develop actions that will improve teamwork and therefore the quality of care to our residents
- The fact that it is participatory - it engages the Home Assistant workforce where they are able to have input into and see the results of the research for themselves
- The potential to develop practical solutions towards building highly effective teams.

Jenny works with Wairarapa Aged Concern and is highly regarded for her professionalism, ethics and concern for the elderly. Where we had questions on the nature and process of the research she has provided satisfactory answers to our committee and we are confident that the level of communication and liaison will continue to be of a very high standard.

The research has been to and approved by our Ethics Committee and the Carter Society Executive Committee. We are therefore happy to write this letter of support.

Yours sincerely

J Chalmers

**Rev Jenny Chalmers**

Carter Society Executive Committee
Chairperson of the Carter Society Ethics Committee

# Appendix 4: University of Otago Ethics Approval

Academic Services
Manager, Academic Committees, Mr Gary Witte

**H16/087**

17 August 2016

Dr W Levack
Department of Medicine (Wgnt)
University of Otago, Wellington
University of Otago Medical School

Dear Dr Levack,

I am again writing to you concerning your proposal entitled **"To develop, implement and test strategies to improve workplace engagement among care workers in an aged residential care facility"**, Ethics Committee reference number **H16/087**.

Thank you for letter of 16th August 2016 addressing the issues raised by the Committee.

On the basis of this response, I am pleased to confirm that the proposal now has full ethical approval to proceed.

The standard conditions of approval for all human research projects reviewed and approved by the Committee are the following:

Conduct the research project strictly in accordance with the research proposal submitted and granted ethics approval, including any amendments required to be made to the proposal by the Human Research Ethics Committee.

Inform the Human Research Ethics Committee immediately of anything which may warrant review of ethics approval of the research project, including: serious or unexpected adverse effects on participants; unforeseen events that might affect continued ethical acceptability of the project; and a written report about these matters must be submitted to the Academic Committees Office by no later than the next working day after recognition of an adverse occurrence/event. Please note that in cases of adverse events an incident report should also be made to the Health and Safety Office:

http://www.otago.ac.nz/healthandsafety/index.html

Advise the Committee in writing as soon as practicable if the research project is discontinued.

Make no change to the project as approved in its entirety by the Committee, including any wording in any document approved as part of the project, without prior written approval of the Committee for any change. If you are applying for an amendment to your approved research, please email your request to the Academic Committees Office:

gary.witte@otago.ac.nz

jo.farrondediaz@otago.ac.nz

Approval is for up to three years from the date of this letter. If this project has not been completed within three years from the date of this letter, re-approval or an extension of approval must be requested. If the nature, consent, location, procedures or personnel of your approved application change, please advise me in writing.

The Human Ethics Committee (Health) asks for a Final Report to be provided upon completion of the study. The Final Report template can be found on the Human Ethics Web Page http://www.otago.ac.nz/council/committees/committees/HumanEthicsCommittees.html

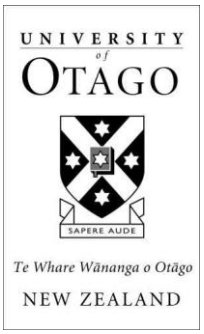
Yours sincerely,

Mr Gary Witte
**Manager, Academic Committees**
Tel: 479 8256
Email: gary.witte@otago.ac.nz

## Appendix 5: Information Sheet

[Reference Number: *as allocated upon approval by the Human Ethics Committee*]

[*Date*]




***WORKPLACE ENGAGEMENT OF HEALTH CARE ASSISTANTS IN RESIDENTIAL AGED CARE***

**INFORMATION SHEET FOR PARTICIPANTS**

Thank you for showing an interest in this project. Please read this information sheet carefully before deciding whether or not to participate. If you decide to participate we thank you. If you decide not to take part there will be no disadvantage to you and we thank you for considering our request.

**What is the Aim of the Project?**

The aim of this study is to develop, implement, and test strategies to improve workplace engagement among care workers in an aged residential care facility. It will specifically explore teamwork, resident centred care practices and professional development opportunities.

This project is part of the requirements for Jenny Prentice's PhD research

**What Types of Participants are being sought?**

The participants will be staff, mostly health care assistants, in an aged residential care facility in Wairarapa DHB. They will be asked to participate in an advisory group of 6-8 participants and /or a wider group of participants to implement actions and provide feedback on the process.

**What will Participants be asked to do?**

Should you agree to take part in this project, you will be invited to participate in some or all of the four steps; Step one – Plan, Step two – Act, Step three – Observe and Step four – Reflect. At each step there will be group discussion and follow-up interviews with small number of some of the group of participants. We will be collecting and analysing information at each step.

- In Step one an advisory group of 6-8 participants will be established. This group will help come up with a plan to make your work more meaningful, engaging and personally satisfying. The advisory group will also provide overall guidance for the remaining stages of the project.
- In Step two, we will aim to implement the plan that the advisory group (in Step one) help develop. This Step will involve recruitment of other care workers from your workplace.
- In Step three the participants will be asked to reflect on their experience of the PAR process and the impact of the actions. We will also be collecting some data to do with workplace practices that are selected as important by the advisory group in Step one.
- In Step four the results will be reported back to all staff the facility for discussion.

The process will be as a voluntary with no-one being required to contribute. If you agree to participate in the study as a whole, you do not need to agree to help with every step the study that you are invited to participate in. You involvement is any part of this study is your choice. You may also decide not to take part in the project to withdraw from the study at any point without any disadvantage to yourself.

**What data or information will be collected and what use will be made of it?**

The group discussions will have information recorded on a whiteboard and also be audio recorded. We use audio recording so that the person running the group discussions does not also have to take notes at the same time and to make sure that we accurately record what people have said. The audio recordings will be transcribed (written out on paper), but we will remove names and other identifying words in these transcripts so that no people will be identified in the transcripts. The researcher and supervisors will have access to the study data. The only other person who will see this data will be a professional typist, who will sign a confidentiality agreement before their involvement in the study. However, if any health and safety or criminal issues raised as part of the discussion these may need to be discussed the facility manager, after this has been discussed with you.

All data collected will be securely stored in such a way that only those mentioned below will be able to gain access to it. Data obtained as a result of the research will be retained for at least 5 years in secure storage. Any personal information held on the participants may be destroyed at the completion of the research even though the data derived from the research will, in most cases, be kept for much longer or possibly indefinitely.

The final results of the project will be written up as a research thesis and will be available in the University of Otago libraries. We may also publish the study in a relevant international science journal. However, every attempt will be made to preserve your anonymity as study participants. Participants will be able to see the final written analysis should they wish to but there will be no identifying data in this paper.

**Can participants change their mind and withdraw from the project?**

You may withdraw from participation in the project at any time prior to the start of the focus group and without any disadvantage to yourself.

**What if participants have any questions?**

If you have any questions about our project, either now or in the future, please feel free to contact either: Jenny Prentice, phone 021557205, email jprentice@clear.net.nz or William Levack, phone (04) 385591 ext 6279, email william.levack@otago.ac.nz.

This study has been approved by the Department stated above. However, if you have any concerns about the ethical conduct of the research you may contact the University of Otago Human Ethics Committee through the Human Ethics Committee Administrator (ph 03 479-8256). Any issues you raise will be treated in confidence and investigated and you will be informed of the outcome.

## Appendix 6: Consent Form

# CONSENT FORM
## WORKPLACE ENGAGEMENT OF HEALTH CARE ASSISTANTS IN RESIDENTIAL AGED CARE

I have read the Information Sheet concerning this project and understand what it is about. All my questions have been answered to my satisfaction. I understand that I am free to request further information at any stage.

I know that:-

1. My participation in the project is entirely voluntary;
2. I am free to withdraw from the project at any time without any disadvantage;
3. Personal identifying information will be destroyed at the conclusion of the project but any raw data on which the results of the project depend will be retained in secure storage for at least five years;
4. The results of the project may be published and will be available in the University of Otago Library (Dunedin, New Zealand) but every attempt will be made to preserve my anonymity.

I agree to take part in this project. Please indicate by ticking the box which Step/s you are agreeing to participate in.

☐ Step One – Advisory Group including group discussion and individual interview

☐ Step Two – Implementing actions

☐ Step Three – Providing observed feedback – group discussion and individual interview

..... .....

(Signature of participant) (Date)

.....

(Printed Name)

UNIVERSITY of OTAGO
Te Whare Wānanga o Otāgo
NEW ZEALAND

## Appendix 7: Evaluation Questions used at Step Three

1. What do you know about the research project that has been conducted in Carter Court? Can you tell me what initiatives have been initiated?

2. Any comments on the process so far? What do you think has been the best initiative/less useful and why?

3. What was it like participating (or not) in the research?

4. What have you noticed is different about working at Carter court since the research began?

5. Could anything have been done differently?

## Appendix 8: Key to Transcription Conventions

The transcripts for this study reflected as closely as possible the actual words and speech patterns of the interview participants. Interview extracts have been edited to illustrate points for the purposes of this paper, but all editing has occurred with the intent of retaining the original meaning of the speech. Ellipses (. . .) have been used to indicate where speech was omitted. Square brackets [ ] were used to insert editorial notes or words not present on the audiotape. Rounded brackets ( ) were used to indicate where nonverbal sounds such as laughter occurred on tape. Em dashes (–) were used in the place of hanging phrases resulting in an incomplete sentence, interruption by another speaker, or where the speaker made a meaningful pause.

## Appendix 9: Timeline for PAR process

| Date | Activity |
|---|---|
| May 2016 | Facility manager agrees to the research being conducted in his facility |
| August | Ethics approval obtained |
| 18 October | Researcher(JP) meets new care manager to begin the recruitment process |
| 9 November | All staff meeting held to give overview of research and recruitment of members of caregiver advisory group |
| 30 November<br>7 December<br>14 December<br>21 December | Advisory group meetings held and all meetings were audio-recorded for later transcription. |
| 14 February 2017<br>15 March<br>18 April<br>18 May | Caregiver-only meetings attended by researcher |

| | |
|---|---|
| 15 May<br>17 May (2 interviews)<br>18 May<br>25 May<br>1 June | Evaluation interviews with facility manager, nurse manager, quality manager, EN and RN, other caregivers and advisory group. All meetings were audio-recorded for later transcription. |
| 30 November | Meeting held by JP to feedback results to staff |